2003 Federal Annual Report
Children's Health Insurance Program

California

Arnold Schwarzenegger, Governor
STATE OF CALIFORNIA
January 2004

The California Managed Risk Medical Insurance Board
1000 G Street, Suite 450
Sacramento, CA 95814
(916) 324-4695 FAX: (916) 324-4878

February 20, 2004

Cheryl Austein-Casnoff
SCHIP Director
Centers for Medicare and Medicaid Services
Mail Stop S2-01-16
7500 Security Blvd.
Baltimore, MD 21244-1850

Dear Ms. Austein-Casnoff:

Enclosed is the Annual Report of the State Children's Health Insurance Program. This report is required to be submitted to the Centers for Medicare and Medicaid Services in compliance with Title XXI of the Social Security Act (Section 2108(a)).

Section 2108(a) of the Act provides that the State must assess the operation of the State Child Health Insurance Program (SCHIP) each fiscal year, and report to the Secretary by January 1 following the end of the fiscal year on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

If you have any questions or comments, please call me or Lorraine Brown, Deputy Director, at (916) 324-4695.

Respectfully,

Joyce I Iseri

for Lesley Cummings
Executive Director

Enclosure

FRAMEWORK FOR THE ANNUAL REPORT OF THE STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble
Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist States in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with States to develop a framework for the Title XXI annual reports.

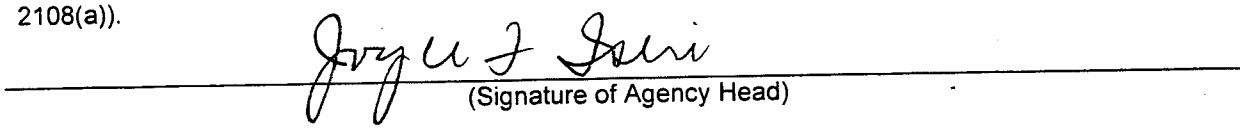
The framework is designed to:

- Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**
- Provide ***consistency*** across States in the structure, content, and format of the report, **AND**
- Build on data ***already collected*** by CMS quarterly enrollment and expenditure reports, **AND**
- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

FRAMEWORK FOR THE ANNUAL REPORT OF THE STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: **California**
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).


(Signature of Agency Head)

SCHIP Program Name(s): Healthy Families / Medi-Cal for Children

SCHIP Program Type:

_____ SCHIP Medicaid Expansion Only
_____ Separate Child Health Program Only
__X__ Combination of the above

Reporting Period: ***Federal Fiscal Year 2003*** *Note: Federal Fiscal Year 2003 starts 10/1/02 and ends 9/30/03.*

Contact Person/Title: **Cynthia Moore, Benefits Specialist**

Address: **1000 G Street, Suite 450, Sacramento, CA 95814**

Phone: **(916) 324-4695** Fax: **(916) 327-9661**

Email: **cmoore@mrmib.ca.gov**

Submission Date: _____

(Due to your CMS Regional Contact and Central Office Project Officer by January 1st of each year)
Please copy Cynthia Pernice at NASHP (cpernice@nashp.org)

SECTION I: SNAPSHOT OF SCHIP PROGRAM AND CHANGES

1) To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in place and would like to comment why, please explain in narrative below this table.

	SCHIP Medicaid Expansion Program					Separate Child Health Program				
Eligibility ***Note: Report template altered to reflect California's eligibility rules.***	From	NA	% of FPL for **infants**	NA	% of FPL	From	200%	% of FPL for **infants**	250 %	% of FPL
	From	NA	% of FPL for children ages **1 through 5**	NA	% of FPL	From	134%	% of FPL for children ages **1 through 6**	250 %	% of FPL
	From	0%	% of FPL for children ages **14 through 18**	100%	% of FPL	From	100%	% of FPL for children ages **7 through 18**	250 %	% of FPL

Is presumptive eligibility provided for children?		No		No
	X	Yes	X	Yes
Is retroactive eligibility available?		No	X	No
	X	Yes, for children and adults for 3 months		Yes
Does your State Plan contain authority to implement a waiting list?	Not applicable		X	No
Does your program have a mail-in application?		No		No
	X	Yes	X	Yes
Does your program have an application on your website that can be printed, completed and mailed in?		No		No
	X	Yes	X	Yes
Can an applicant apply for your program over phone?	X	No	X	No
		Yes		Yes
Can an applicant apply for your program on-line?	X	No		No
	Yes – please check all that apply		X	Yes – please check all that apply (through a Certified Application Assistant)
		Signature page must be printed and mailed in	X	Signature page must be printed and mailed in
		Family documentation must be mailed (i.e., income documentation)	X	Family documentation must be mailed (i.e., income documentation)
		Electronic signature is required	X	Electronic signature is required
				No Signature is required
Does your program require a face-to-face interview during initial application	X	No	X	No
		Yes		Yes

Does your program require a child to be uninsured for a minimum amount of time prior to enrollment (waiting period)?	X	No		No
		Yes	X	Yes, if Employer Sponsored Insurance. Note: Exceptions to waiting period should be listed in Section III, subsection Substitution, question 6
	specify number of months		specify number of months	3 months
Does your program provides period of continuous coverage <u>regardless of income changes?</u>		No		No
	X	Yes	X	Yes
	specify number of months	12	specify number of months	12
	Explain circumstances when a child would lose eligibility during the time period in the box below		Explain circumstances when a child would lose eligibility during the time period in the box below	
	Death of the child, leave the State, applicant's request		Reach age 19, non-payment of premiums, death of the child, leave the State, applicant's request	
Does your program require premiums or an enrollment fee?	X	No		No
		Yes	X	Yes
	Enrollment Fee	$	Enrollment Fee	$ 0
	Premium Amount	$ $ Yearly cap	Premium Amount	$ 4–9/mo $ 0 Yearly cap
	Briefly explain fee structure in the box below		Briefly explain fee structure in the box below	
			$4 to $9 per month per child with a maximum of $27/month for a family. Applicant may pay three months and receive the fourth free. If the applicant uses Electronic Funds Transfer, he/she receives a 25% discount.	
Does your program impose copayments or coinsurance?	X	No		No
		Yes	X	Yes (Preventive services have no copayment. Copayments for other services limited to $5)
Does your program require an assets test?	X	No	X	No
		Yes		Yes
	If Yes, please describe below		If Yes, please describe below	
Is a preprinted renewal form sent prior to eligibility expiring?	X	No		No
	Yes, we send out form to family with their information precompleted and		Yes, we send out form to family with their information precompleted and	
		ask for confirmation	X	ask for confirmation (and verification of income)
		do not require a response unless income or other circumstances have changed		do not require a response unless income or other circumstances have changed

2. Are the income disregards the same for your Medicaid and SCHIP Programs? [X] Yes [ ] No

3. Is a joint application used for your Medicaid, Medicaid Expansion and SCHIP Programs? [X] Yes [ ] No

4. Have you made changes to any of the following policy or program areas during the reporting period? Please indicate "yes" or "no change" by marking appropriate column.

	Medicaid Expansion SCHIP Program		Separate Child Health Program	
	Yes	No Change	Yes	No Change
a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)		X		X
b) Application		X		X
c) Benefit structure		X		X
d) Cost sharing structure		X		X
e) Cost sharing collection process		X		X
f) Crowd out policies		X		X
g) Delivery system		X		X
h) Eligibility determination process (including implementing a waiting lists or open enrollment periods)		X	X	
i) Eligibility levels / target population		X		X
j) Eligibility redetermination process		X		X
k) Enrollment process for health plan selection		X		X
l) Family coverage		X		X
m) Outreach (e.g., decrease funds, target outreach)		X	X	
n) Premium assistance		X		X
o) Prenatal Eligibility expansion		X		X
p) Waiver populations (funded under title XXI)		X		X
Parents		X		X
Pregnant women		X		X
Childless adults		X		X
q) Other – please specify				
a. _____				
b. _____				
c. _____				

5. For each topic you responded yes to above, please explain the change and why the change was made, below.

a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	
b) Application	
c) Benefit structure	
d) Cost sharing structure or e) Cost sharing collection process (separate?)	
f) Crowd out policies	
g) Delivery system	
h) Eligibility determination process (including implementing a waiting lists or open enrollment periods)	Implementation of presumptive eligibility through the State's Children's Health and Disability Prevention (CHDP) Program
i) Eligibility levels / target population	
j) Eligibility redetermination process	
k) Enrollment process for health plan selection	
l) Family coverage	
m) Outreach	Lost budgeted funding for Application Assistants
n) Premium assistance	
o) Prenatal Eligibility Expansion	
p) Waiver populations (funded under title XXI)	
Parents	
Pregnant women	
Childless adults	
q) Other – please specify	
a.	
b.	
c.	

SECTION II: PROGRAM'S STRATEGIC OBJECTIVES AND PERFORMANCE GOALS

1. In the table below, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List your State's strategic objectives for your SCHIP program and if the strategic objective listed is new/revised or continuing.

Column 2: List the performance goals for each strategic objective.

Column 3: For each performance goal, indicate how performance is being measured and progress toward meeting the goal. Specify if the strategic objective listed is new/revised or continuing, the data sources, the methodology and specific measurement approaches (e.g., numerator and denominator). Please attach additional narrative if necessary.

Note: *If no new data are available or no new studies have been conducted since what was previously reported, please complete columns 1 and 2 and enter "NC" (for no change) in column 3*.

Please note that all objective and performance goals are continuing.

(1) Strategic Objectives	**(2) Performance Goals for each Strategic Objective**	**(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)**
Objectives related to Reducing the Number of Uninsured Children		
New/revised _____ Continuing __X__ 1. Increase Awareness	1.1 Increase the percentage of Medi-Cal eligible children who are enrolled in the Medi-Cal program.	Data Sources: CA Department of Health Services (DHS) Methodology: Analyze changes in number of eligible children in Medicaid in FFY 2002 and FFY 2003. Progress Summary: See narrative on page 12.
	1.2 Reduce the percentage of uninsured children in target income families that have family income above no-cost Medi-Cal.	Data Sources: "*The State of Health Insurance in California: Findings from the 2001 California Health Interview Survey"* (Brown, et. al., UCLA 2002). Methodology: Analyze changes in number of eligible uninsured children during FFY 2003. Progress Summary: See narrative on page 12.

(1) Strategic Objectives	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
	1.3. Reduce the percentage of children using the emergency room as their usual source of primary care.	Data Sources: See progress summary. Methodology: See progress summary. Progress Summary: The Managed Risk Medical Insurance Board (MRMIB) is assessing the utility of this measure as a predictor of the contribution the HFP has in lowering the rates at which children are using the emergency room as their usual source of primary care. Adjustments to the data to account for confounding factors are complex. It is likely that this strategic objective will be replaced or eliminated in the 2004 Federal Annual Report.
Objectives Related to SCHIP Enrollment		
New/revised _____ Continuing __X__ 2. Provide an application and enrollment process which is easy to understand and use.	2.1. Ensure Medi-Cal and HFP enrollment contractor provide written and telephone services spoken by target population.	Data Sources: Enrollment Contractors/Enrolled Entities Methodology: Review and survey of current materials. Progress Summary: See narrative on page 13.
New/revised _____ Continuing __X__ 3. Ensure that financial barriers do not keep families from enrolling their children.	3.1. Limit program costs to two percent of annual household income.	Data Sources: Internal Enrollment Data, program design data, survey data Methodology: Review and analysis. Progress Summary: See narrative on page 13.
New/revised _____ Continuing __X__ 4. Ensure the Participation of Community Based Organizations in Outreach/Education Activities.	4.1. Ensure that a variety of entities experienced in working with target populations are eligible for an application assistance fee.	Data Sources: MRMIB/DHS financial records Methodology: Summary of expenses for application assistance from State FY 02/03. Progress Summary: See narrative on page 14.

(1) Strategic Objectives	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
	4.2. Ensure that a variety of entities experienced in working with target populations and have subcontracts have input to the development of culturally and linguistically appropriate outreach and enrollment materials.	Data Sources: Outreach and Education Contracts/Enrolled Entity Survey Methodology: Review contract listing. Progress Summary: See narrative on page 14.
Objectives Related to Increasing Medicaid Enrollment		
Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need)		
New/revised _____ Continuing __X__ 5. Provide a choice of health plans.	5.1. Provide each family with two or more health plan choices for their children.	Data Sources: Enrollment data from the HFP Administrative Vendor - Electronic Data Systems (EDS) Methodology: Data extract and reports from vendor database of percent of enrollment by county and number of health plans per county. Progress summary: See narrative on page 14.
New/revised _____ Continuing __X__ 6. Encourage the inclusion of traditional and safety net providers.	6.1. Increase the number of children enrolled who have access to a provider within their zip code.	Data Sources: Data from administrative vendor/provider locations from GeoAccess Methodology: Review change in penetration pre- and post-HFP implementation. Progress Summary: Approximately **2.38%** of total subscribers live in a zip code that has no provider. This is an improvement from the 2001 report where 6.8% of subscribers lived in a zip code with no provider.

(1) Strategic Objectives	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
	6.2. Increase the number of children enrolled who have access to a traditional and safety net provider as defined by MRMIB.	Data Sources: Health Plan Traditional & Safety Net Provider Report CPP Designations Methodology: Reports submitted by HFP participating health plans on the number of children who have a Traditional and Safety Net provider as their PCP. Progress Summary: See narrative on page 15.
New/revised _____ Continuing __X___ 7. Ensure that all children with significant health needs receive access to appropriate services.	7.1. Maintain or improve the percentage of children with services.	Data Sources: HFP enrollment, CCS, and County mental health data. Methodology: Review and analysis of mechanisms in place to serve children with significant health problems. Track complaints from children with special needs. Progress Summary: See narrative on page 15.
	7.2. Ensure no break in coverage as they access specialized services.	Data Sources: HFP enrollment, CCS, County mental health data Methodology: Review and analysis of mechanisms in place to serve children with significant health problems. Track complaints from children with special needs. Progress Summary: See narrative on page 15.
Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)		
New/revised _____ Continuing __X___ 8. Ensure health services purchases are accessible to enrolled children.	8.1. Achieve year to year improvements in the number of children that have had a visit to a primary care physician during the year.	Data Sources: HEDIS Measures Methodology: Compiling HEDIS measure data in total and for selected demographic variables. Progress Summary: Please see attached report titled, *Quality Measurement Report 2002.*

(1) Strategic Objectives	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
	8.2 Achieve year to year improvements in the number of children who have had a child exam at appropriate interval.	Data Sources: HEDIS Measures Methodology: Compiling HEDIS measure data in total and for selected demographic variables. Progress Summary: Please see attached report titled, *Quality Measurement Report 2002.*
	8.3. Achieve year to year improvements in the number of children who have received immunizations by age 2 and age 13.	Data Sources: HEDIS Measures Methodology: Compiling HEDIS measure data in total and for selected demographic variables. Progress Summary: Please see attached report titled, *Quality Measurement Report 2002.*
Other Objectives		
New/revised _____ Continuing **X** 9. Strengthen and encourage employer-sponsored coverage to maximum extent possible.	9.1 Maintain the proportion of children under 200% FPL who are covered under an employer based plan. Adjust for increased costs.	Data Sources: Survey performed by the University of California, San Francisco (UCSF) August 2002. Methodology: Random sample of recent enrollees. Progress Summary: UCSF estimates crowd-out at 8%. Of this 8%, 75% indicated that they could not afford other insurance. These numbers indicate that crowd-out has not affected the HFP to any significant degree.

Narrative 1.1 Increase the percentage of Medi-Cal eligible children who are enrolled in the Medi-Cal program.

There has been an overall increase in the total number of children in Medi-Cal between June 2002 and June 2003. The increase may be largely attributed to the 24.10% increase in the number of children in the Regular Medicaid program. There was a significant increase (57.46%) in the number of children in the One-Month Bridge Program, and a notable increase (12.67%) in the children in the Medicaid Expansion Program.

Children Enrolled in Medi-Cal and One Month Bridge

	June 2002	June 2003	Change	Percent Change
Total Medicaid	3,017,209	3,159,925	142,716	4.73%
Regular Medicaid	2,970,920	3,104,276	133,356	4.49%
Medicaid Expansion	46,289	52,155	5,866	12.67%
One Month Bridge	2,219	3,494	1,275	57.46%

From Healthy Families Medicaid Expansion, Regular Medicaid, and One Month Bridge Eligibles Later Updates to the Data for the CHIP Quarterly Statistical Reporting on the CMS-64 21E (Line Item #6), HCFA-64EC and CMS-21E 10/30/2003. Prepared by Fiscal Forecasting and Data Management Branch.

On July 1, 2002, the DHS implemented accelerated eligibility for children screened for Medi-Cal eligibility to have immediate access to medical, dental and vision care while the county social services departments determine Medi-Cal eligibility. These efforts and changes have had a combined effect of making it easier for families and children to apply for and stay on Medi-Cal.

Narrative 1.2 Reduce the percentage of uninsured children in target income families that have family income above no cost Medi-Cal.

Denominator- HFP eligible baseline (see Section III, Questions 2,4 and 5, pages 20-21, for a detailed description)*

D = New estimated number of uninsured children in target income families
= 759,000

Numerator- Actual number of uninsured children insured under HFP during the reporting period.

N = Actual number of uninsured children insured under HFP during reporting period.
= 654,000

Progress toward goal- Estimated reduction in the percentage of uninsured children in target income families that have family income above no cost Medi-Cal:

P = N/D
= 86%

*** NOTE:** The HFP eligible baseline was established using data from the first biennial California Health Interview Survey (CHIS). The CHIS was conducted in 2001. Results from the second CHIS (conducted in 2003) will be released in 2004.

Narrative 2.1. Ensure Medi-Cal and HFP enrollment contractor provide written and telephone services spoken by target population.

Applicants can receive enrollment instructions, applications, and handbooks in ten languages. These languages include English, Spanish, Vietnamese, Khmer (Cambodian), Armenian, Cantonese, Korean, Russian, Hmong and Farsi. In addition, HFP has all correspondence, billing invoices, and other program notification materials available in five languages: English, Spanish, Chinese, Korean, and Vietnamese.

The program's administrative vendor maintains toll-free lines to provide pre-and post enrollment assistance. These lines operate Monday through Friday from 8:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 5:00 p.m. The toll-free HFP information line (800-880-5305) and the Medi-Cal outreach line (888-747-1222) are staffed with enrollment specialists who can provide HFP and Medi-Cal information, provide enrollment assistance, and give families information on the status of their application. The table below displays the frequency of calls received on the HFP information line by language.

The line is staffed by a team of operators proficient in the eleven designated languages in which campaign materials are published. The following table describes the frequency of calls by language.

Language	HFP/MCC Single Point of Entry		HFP/MCC Outreach	
	Program to Date	% of Total	Program to Date	% of Total
English	2,646,830	57.48%	913,289	70.03%
Spanish	1,635,936	35.53%	348,950	26.76%
Cantonese	140,711	3.06%	13,024	1.00%
Korean	78,483	1.70%	6,988	0.54%
Vietnamese	53,617	1.16%	15,984	1.23%
Armenian	24,289	0.53%	889	0.07%
Russian	9,932	0.22%	2,042	0.16%
Farsi	5,952	0.13%	725	0.06%
Cambodian	3,622	0.08%	864	0.07%
Hmong	4,231	0.09%	1,461	0.11%
Laotian	1,005	0.02%	1	< 0.01%

In July 2001 a special toll free member services number (866-848-9166) was implemented to assist members with inquiries about and/or changes to their account, and provide members with information about eligibility appeals. The HFP member services call line operates Monday through Friday between 8 a.m. and 8 p.m. and on Saturday between 8 a.m. and 5 p.m.

Narrative 3.1 Limit program costs to two percent of annual household income.

California continues to limit HFP costs to below two percent of annual household income. The following table represents the aggregate distribution of income and premiums for enrollees during the reporting period. The maximum weighted average program costs based on the mix of actual program enrollees as a percent of income was 1.4%.

This analysis assumes an average family size of 4.4 and expending the maximum health copayment of $250. The $250 copayment equals 50 visits or prescriptions per year at $5 per visit or prescription. During the 2002/2003 benefit year, 0.08% of HFP members reached the copayment maximum.

Aggregate Income and Premium Statistics

Countable Income	Percent of Subscribers	Average Annual Premium	Maximum Allowable Health Copayments	Maximum Total Program Cost	Average Annual Income	Maximum Program Cost as a Percent of Income
Under 150%(fpl)	36.5%	$133	$250	$383	$25,249	1.5%
Over 150%(fpl)	63.5%	$188	$250	$438	$35,922	1.2%

Narrative 4.1 and 4.2. Ensure the Participation of Community Based Organizations in Outreach and Education Activities.

Community-based organizations continue to be an integral part of the HFP and Medi-Cal Program outreach strategy. As of September 30, 2003, 58.6% of applications received through the Single Point of Entry (SPE) process were assisted by organizations that participated in the application assistance fee program. The most common type of community based organization serving as enrollment entities are insurance agents, medical service providers (clinics, providers, and hospitals), and community based programs. Medical service providers submit the largest number of applications to SPE compared to all other organizations.

Due to the State's fiscal crisis, effective July 1, 2002, all advertising campaigns and outreach contracts with community based organizations (CBOs) were cancelled. To mitigate impact on outreach efforts, the DHS contracted with two additional organizations to train Certified Application Assistants (CAA[s]). These contractors helped the State to reduce the training request backlog and trained CAAs in the Los Angeles area and more rural Northern California counties. These contracts expired on June 2003.

To sustain CAA training in the absence of state funding, MRMIB solicited interest in becoming CAA master trainers from enrollment entities. Interested organizations would provide training to potential CAAs at not cost to the State. CAA master training was provided by MRMIB to 15 representatives from 10 health plans participating in the Healthy Families Program, and to 23 representatives from various community based organizations throughout the State. MRMIB also developed an interim process to certify CAAs who successfully completed the CAA training provided by these organizations. MRMIB will continue to train CAA master trainers until the new HFP administrative vendor assumes this function in early 2004. Contact information for CAA master trainers is posted on the HFP website (www. healthyfamilies.ca.gov). To date, over 100 new CAAs have been trained and certified to assist families in completing their application.

In light of the elimination of CAA reimbursements, MRMIB, in partnership with the 100% Campaign (a coalition of child advocates) surveyed enrollment entities (such as community based organizations, insurance companies and health plans) to ascertain how many would continue to provide application assistance without the assistance fee. Of the 4,500 enrollment entities surveyed, 30 percent (1,352) indicated that they would continue providing assistance and 25 percent (1,116) indicated they would accept referrals from the State's toll-fee number for assistance.

Narrative 5.1. Provide each family with two or more health plan choices for their children.

HFP offers a broad range of health plans for program subscribers. A total of 27 health plans participated in the program during the reporting period. Over 99% of subscribers have a choice of at least two health plans from which to select. The 1% of subscribers who have a choice of only one health plan mostly reside in rural areas of the state where access to health care services are limited. These subscribers are enrolled in exclusive provider organization plans (EPO) that provide a broad network of providers. In 37 of 58 counties, subscribers have a choice of up to 3 or more health plans. . In 3 of these 37 counties, members can choose from up to 7 health plans. In 2 of these 37 counties, subscribers have 8 health plans from which to choose.

Narrative 6.2 Increase the number of children enrolled who have access to a traditional and safety net provider as defined by MRMIB.

As an incentive to include traditional and safety net providers in their network, health plans with the highest percentage of traditional and safety net providers in their network are designated as a Community Provider Plan (CPP). Seventeen of 27 participating health plans are designated as a Community Provider Plan (CPP) in at least one county. Plans with the CPP designation are offered at a $3 discount per child per month on the monthly premium discount. Of all HFP subscribers, over 321,700 (39.1%) are enrolled in a CPP and receive a $3 monthly premium discount. Of those enrolled in a CPP, over 60% are Hispanics and Asian/ Pacific Islanders. This group represents over 75% of HFP's total subscriber population.

Traditional and safety net providers (TSN) are available in all areas of the state, and all HFP subscribers have access to them. Of the 23 HFP participating health plans that require subscribers to select a primary care provider (PCP), an average of 62% of the plans' subscribers had a TSN provider as their PCP. Sixty-four percent of Hispanic subscribers and 63% of Asian/Pacific Islanders have a TSN provider as their PCP. This percent has not varied significantly over the past three years. Subscribers in families designating Korean as their primary language spoken had the highest utilization rate (73%) of TSN providers as PCPs then the four other dominate language groups in the program.

Narrative 7.1 and 7.2 Ensure that all children with significant health needs receive access to appropriate services.

Children enrolled in the HFP are referred to the California Children's Services (CCS) Program or county mental health departments, depending upon their special health care needs. These referrals may originate with the health plans participating in the HFP, or from other sources such as schools or families. Reports submitted by participating plans indicated that 8,578 children were referred to the CCS program and that 1,622 children were referred to a county mental health program during the 2002/03 State fiscal year. The State has two administrative systems to facilitate the tracking of these children.

The State continues to monitor access to services for children with special health care needs as it has since the inception of the program. The State holds routine meetings with health, dental and vision plans and the CCS and county mental health programs and follows-up on complaints received from subscribers. The routine meeting with plans and the programs allow the State and plans to discuss any arising or foreseeable barriers to access, and ways to eliminate these barriers. Newsletters were developed for county mental health programs to reinforce referral protocols for health plan/county mental health referrals and to provide county mental health departments with updates on the HFP. The California Institute of Mental Health in collaboration with the State developed these newsletters. During the reporting period, brochures were distributed to families to better educate them about the CCS and county mental health programs.

2. How are you measuring the access to, or the quality or outcomes of care received by your SCHIP population? What have you found?

MRMIB continues to obtain information on quality of care through health and dental plan reporting requirements and subscriber surveys. The sources of information used to obtain data on the quality of care delivered through health, dental and vision plans includes the following:

Fact Sheets
Fact Sheets are submitted by each health, dental and vision plan interested in participating in the HFP. The questions that are included in the Fact Sheet request information about the organization of the plans and the provision of health, dental and vision care services. Some of the specific areas that are addressed include access to providers, access to plan services, including customer service, standing with regulatory entity or accrediting body, and process for handling member grievances. Fact Sheets are submitted by the plans annually.

Annual Quality of Care Reports
Each year, health and dental plans are required to submit quality of care reports based on HEDIS® and a 120-day health (and dental) assessment measure. The HEDIS® reports for health plans focus

on the number of children who have been immunized and on the number of children receiving well child visits. Because preventive care is vital to young children and is the cornerstone of care provided through the HFP, the annual quality of care reports provide an indication of how well a particular plan is providing health or dental care to members. In examining data for the last three years, the HFP has consistently met or exceeded the scores for commercial and Medicaid plans in child-relevant HEDIS® measures. A copy of the report is attached.

California Children's Services (CCS) and Mental Health Referral Reports

The CCS and Mental Health Referral Reports were implemented in FFY 2000 to monitor the access that eligible children have to CCS and county mental health services. On a quarterly basis, plans are required to report the number of children referred to these services. The numbers reported by plans are compared with the estimates of children expected to require CCS and county mental health services to determine whether there is adequate access to these services.

Cultural and Linguistics Services Report

This report allows staff to monitor how HFP subscribers' special needs related to language access, and culturally appropriate services are being met. The Cultural and Linguistic Services Report outlines how plans provide culturally and linguistically appropriate services to subscribers. Specific information obtained for the report included:

- How plans assign subscribers to culturally and linguistically appropriate providers
- How plans provide interpreter services to subscribers
- How plans provide culturally and linguistically appropriate marketing materials
- A list of written materials plans make available in languages other than English

Participating plans were also required to do a Group Needs Assessment Report. The Group Needs Assessment Report identifies the unique perspectives of subscribers based on their cultural beliefs.

The assessment included an evaluation of community resources for providing health education and cultural and linguistic services and the adequacy of the network. Based on the results of the assessment, each plan is required to develop a program to address the needs identified in the group needs assessment. Participating plans submitted their first group needs assessment reports in June 2001.

Plans have identified certain cultural and linguistic needs of their subscribers and have implemented activities to address those needs. The state and the HFP plans continued to monitor and dialog during the reporting period and are coordinating processes to determine effectiveness over time of plan efforts. The 2002 Quality Measurement Report suggests that disparities in access to health care across ethnic and linguistic groups are not present in the HFP. For more information regarding these results, see attached report titled *Quality Measurement Report – 2002.*

Member Surveys

MRMIB uses two types of member surveys to monitor quality and service. During open enrollment, all subscribers are given a plan disenrollment survey. The survey requests information on why members decided to switch plans during open enrollment. Questions on the survey address plan quality, cost, adequacy of the provider network, and access to primary care providers. For further information, please see the attached Open Enrollment Survey report.

Consumer satisfaction surveys, for both health and dental plans, are conducted each year. The surveys are conducted in five languages (English, Spanish, Chinese, Korean, and Vietnamese) and are based on the Consumer Assessment of Health Plans Survey (CAHPS® 2.0H). Responses from the surveys provide information on access to care (including specialty referrals), quality of provider communication with subscribers, and ratings of providers, health and dental plans and overall health and dental care. Significant findings for the program in the 2002 CAHPS® 2.0H include:

- On a scale of 0–10 with "10" being the best care and "0" being the worst, 80 percent of families gave their health care, health plan, personal doctor (or nurse) and specialist a rating of at least an 8. The aspect of care receiving the highest percentage of families giving high

ratings was in the overall rating of the health plan. Eighty-seven percent of families rated their plan an 8, 9 or 10.

- The percentage of families giving their health plan high ratings ***increased*** in 2002. In the 2002 survey, 87 percent of families gave their plan a high rating. In the 2001 survey, 85 percent of families gave their plan a high rating.
- 88 percent of families responded positively when asked questions about how well doctors communicate.

For additional information, please see attached report.

In September 2002, the MRMIB conducted the second Dental CAHPS® Survey (D- CAHPS® 1.0) to measure subscribers' experiences with dental care and to provide existing and potential HFP applicants with information about their dental plan options. Significant findings for the program in the D-CAHPS® 1.0 include:

- Approximately 65, 66 and 69 percent of families responded positively when asked questions rating their dental plan, dentist's care, and personal dentist, respectively.
- 75 percent of families responded positively when asked questions rating their specialist.
- 81 percent of families responded positively when asked questions rating how well their dentist communicates.
- 80 percent responded positively when asked questions rating courteousness and helpfulness of office staff.

For further information, please see attached report.

Subscriber Complaints
MRMIB receives direct inquiries and complaints from HFP applicants. Approximately 90 percent of the inquiries are received via correspondence and ten percent through phone calls. All HFP inquiries and complaints are entered into a data file that is categorized by the subscriber's plan, place of residence, the families' primary languages and type of request. This data enables staff to track complaints by plan and to: 1) monitor access to medical care by plan, 2) evaluate the quality of health care being rendered by plan, 3) evaluate the effectiveness of plans in processing complaints, and 4) monitor the plan's ability to meet the linguistic needs of subscribers.

3. What plans does your SCHIP program have for future measurement of the access to, or the quality or outcomes of care received by your SCHIP population? When will data be available?

The State will be adding performance measures to new health and dental plan contracts that are scheduled for July 2005. In addition, the State has established the means to collect encounter/claims data from health and dental plans participating in the program. Based on recommendations from the HFP Quality Improvement Work Group, the focus of encounter/claims data collection will include emergency room admissions for asthma, diabetes-Type II, Attention Deficit Hyperactivity Disorder (ADHD) and depression treatment provided in the pediatrician's office and psychotrophic medications, and appropriate treatment for children with upper respiratory infection (based on HEDIS®). This mechanism will be implemented once the new health and dental plan contracts have been executed.

In addition to new measures, the state will also explore the development of performance targets for preventive services and requirements for corrective actions when plans do not meet designated targets.

4. Have you conducted any focused quality studies on your SCHIP population, e.g., adolescents, attention deficit disorder, substance abuse, special heath care needs or other emerging health care needs? What have you found?

The Health Status Assessment Project is in the last year of its three year-run to evaluate the changes in health status of children newly enrolled in the HFP. The project examines the physical and psychosocial benefits of having access to comprehensive medical, dental and vision insurance. The Project is being conducted with financial support from the David and Lucile Packard Foundation.

Key findings from results after one year of enrollment are:

- The HFP meaningfully improved the health-related quality of life for children in the greatest need;
- The HFP had a positive impact on children with chronic health conditions;
- Meaningful improvements in health-related quality of life were achieved within ethnic demographics;
- The HFP improved access to care for its members;
- Children in the poorest health missed less school and improved school performance due to enrollment in the HFP; and
- Families participating in the HFP are excited about the program and are willing to participate.

5. Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here and summarize findings.

- Quality Measurement Report—2002
- 2003 Consumer Assessment of Health Plans Survey
- 2003 Consumer Assessment of Dental Plans Survey
- 2003 Open Enrollment Summary Report

REPORTING OF NATIONAL PERFORMANCE MEASURES

The Centers for Medicare & Medicaid Services (CMS) convened the Performance Measurement Partnership Project (PMPP) as a collaborative effort between Federal and state officials to develop a national set of performance measures for Medicaid and the State Children's Health Insurance Programs (SCHIP). CMS is directed to examine national performance measures by the SCHIP Final Rules of January 11, 2001 and the Medicaid Final Rules of June 14, 2002 on managed care.

The PMPP's stated goal is to create a short list of performance measures relevant to those enrolled in Medicaid and SCHIP. The group focused on well-established measures whose results could motivate agencies, providers, and health plans to improve the quality of care delivered to enrollees. After receiving comments from Medicaid and SCHIP officials on an initial list of some 19 measures, the PMPP group trimmed the list to the following seven core measures (SCHIP states should report on all applicable measures for covered populations to the extent that data is available):

- Well child visits for children in the first 15 months of life
- Well child visits in the 3rd, 4th, 5th, and 6th years of life
- Use of appropriate medications for children with asthma
- Comprehensive diabetes care (hemoglobin A1c tests)
- Children's access to primary care services
- Adult access to preventive/ambulatory health services
- Prenatal and postpartum care (prenatal visits)

Work remains to resolve technical issues related to implementing the collection, analysis, and reporting of the measures. ***If your State currently has data on any of these measures***, please report them using the format below. Indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator and denominator). Please attach additional narrative if necessary.

Measure	**Describe how it is measured**	
Well child visits for children in the first 15 months of life		Data Sources: Methodology: Progress Summary:
Well child visits in the 3rd, 4th, 5th, and 6th years of life	HEDIS® Use of Services domain; expresses percentage of subscribers continuously enrolled in an HFP plan for a specified period of time and received well child visits.	Data Sources: HEDIS® measures Methodology: Compiling HEDIS® data for selected demographic variables. Progress Summary: Please see attached report titled, *Quality Measurement Report 2002.*
Use of appropriate medications for children with asthma		Data Sources: Methodology: Progress Summary:
Comprehensive diabetes care (hemoglobin A1c tests)		Data Sources: Methodology: Progress Summary:
Children's access to primary care services	HEDIS® Access/Availability domain; describes how subscribers access basic primary care services from their HFP plan. Access refers to the ability of subscribers to obtain the services they require.	Data Sources: HEDIS® measures Methodology: Compiling HEDIS® data for selected demographic variables. Progress Summary: Please see attached report titled, *Quality Measurement Report 2002.*

Adult access to preventive/ambulatory health services		Data Sources: Methodology: Progress Summary:
Prenatal and postpartum care (prenatal visits)		Data Sources: Methodology: Progress Summary:

SECTION III: ASSESSMENT OF STATE PLAN AND PROGRAM OPERATION

ENROLLMENT

1. Please provide the Unduplicated Number of Children Ever Enrolled in SCHIP in your State for the reporting period. The enrollment numbers reported below should correspond to line 7 in your State's 4th quarter data report (submitted in October) in the SCHIP Statistical Enrollment Data System (SEDS).

99,366 SCHIP Medicaid Expansion Program (SEDS form 64.21E)

822,866 Separate Child Health Program (SEDS form 21E)

2. Please report any evidence of change in the number or rate of uninsured, low-income children in your State that has occurred during the reporting period. Describe the data source and method used to derive this information.

California uses the California Health Interview Survey (CHIS) as its primary source of data for the number of uninsured. This data source was adopted because it is believed to be more precise than prior estimates based upon CPS data. Results from the first survey were released in June 2002. The survey is scheduled to be conducted every two years, with second survey results scheduled for release in 2004.

Between 2000 and 2001, the CHIS estimated number of uninsured children eligible for either HFP or Medi-Cal and not enrolled was approximately 656,000. During this reporting period, enrollment in the HFP grew from 596,000 to 654,000.

(States with only a SCHIP Medicaid Expansion Program please skip to #4)

3. How many children do you estimate have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

While the State does not actively collect data estimating the impact of outreach and enrollment simplification, the State believes outreach and enrollment simplification both play a major role in Medi-Cal's continuing increase in enrollment.

4. Has your State changed its baseline of uncovered, low-income children from the number reported in your previously submitted Annual Report?

Note: The baseline is the initial estimate of the number of low-income uninsured children in the State against which the State's progress toward covering the uninsured is measured. Examples of why a State may want to change the baseline include if CPS estimate of the number of uninsured at the start of the program changes or if the program eligibility levels used to determine the baseline have changed.

X No, skip to the Outreach subsection, below

____ Yes, please provide your new baseline ____ And continue on to question 5

5. On which source does your State currently base its baseline estimate of uninsured children?

____ The March supplement to the Current Population Survey (CPS)

X A State-specific survey

____ A statistically adjusted CPS

____ Another appropriate source

A. What was the justification for adopting a different methodology?

B. What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Provide a numerical range or confidence intervals if available.)

C. Had your State not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

OUTREACH

1. How have you redirected/changed your outreach strategies during the reporting period?

Reflecting continued fiscal constraint, on June 30, 2003 CAA reimbursement by the State ended. In partnership with the 100% Campaign, MRMIB surveyed enrollment entities comprised of CBOs, insurance companies and health plans to ascertain how many of them would continue to provide application assistance without the fee being provided as in prior years. Out of 4,500 enrollment entities, 30 percent (1,352) are continuing to provide assistance, and 25 percent (1,116) will accept referrals for assistance from the State's toll-free number.

MRMIB provided CAA Master Trainer training to 15 representatives from 10 contracted Health Plans and 23 representatives from various community based organizations throughout the State. MRMIB also developed an interim process to certify CAAs who successfully completed the CAA training provided by these organizations. This function was previously contracted out by DHS but ended in June 2003. This process will continue until the new HFP administrative vendor assumes these duties early in 2004. Contact information for CAA Master Trainers is posted on the HFP website (www.healthyfamilies.ca.gov). To date, over 100 new CAAs have been trained and certified to assist families in completing applications through this process.

MRMIB convened a quarterly statewide outreach workgroup meeting to focus on coordination of outreach activities. Information sharing, CBO partnering and networking was also facilitated.

MRMIB also partnered with the David and Lucile Packard Foundation to sponsor the Connecting Kids Through Schools Project. This project was previously sponsored by the California Department of Health Services. The project focuses on school-based enrollment for the Healthy Families and Medi-Cal programs. A recent telephone survey showed that schools are the number one referral source of program information for 40-45% of families surveyed.

2. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

In the past, the education and outreach campaign has consisted of a combination of advertising, collateral materials, public relations, community and school-based outreach, and certified application assistance. All of these efforts reinforced each other in targeting eligible children for the HFP and Medi-Cal for Children Program. The CAAs continue to be the primary outreach vehicle with a consistent average of 58.6% of all applications for HFP and Medi-Cal for Children Program being assisted by a CAA. For more application information, please see the 2002 Single Point of Entry Fact Book available at www.mrmib.ca.gov – Special Reports.

To initiate the relationship between a CAA and new applicants, the HFP administrative vendor provided CAA referral services to families who needed assistance in completing their application. This information is available on-line via the HFP website (www.healthyfamilies.ca.gov – Find an Enrollment Entity in Your Area) or by calling the toll-free information number (1-800-880-5305). The on-line service was an internet link to a DHS database. Due to the elimination of the CAA assistance fee in June 2003, this resource was no longer reliable and was removed from the HFP website. However, those Enrollment Entities, who expressed a continued interest through the 100% Campaign survey to accept referrals, are provided to callers and applicants through various toll free lines at the HFP (e.g., SPE Line, HeApp Help Desk, etc.).

3. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

During the reporting period, fiscal challenges continued to strain program outreach. Past targeted outreach efforts have necessarily been discontinued.

SUBSTITUTION OF COVERAGE (CROWD-OUT)

(All States must complete the following 3 questions)

1. Describe how substitution of coverage is monitored and measured.

The manner in which the State monitors and measures substitution of coverage has not changed since the inception of the program in 1998. Crowd-out is monitored through the eligibility determination process and the collection of employer-sponsored insurance at the time of application data. Applicants are required to answer questions about each child's previous health coverage. Children who received employer-based health coverage 90 days prior to application are not eligible for the HFP, unless they qualify for specific exemptions. These exemptions include:

- The person or parent providing health coverage lost or changed jobs;
- The family moved into an area where employer-sponsored coverage is not available;
- The employer discontinued health benefits to all employees;
- Coverage was lost because the individual providing the coverage died, legally separated, or divorced;
- COBRA coverage ended; or
- The child reached the maximum coverage of benefits allowed in current insurance in which the child is enrolled.

2. Describe the effectiveness of your substitution policies and the incidence of substitution. What percent of applicants, if any, drop group health plan coverage to enroll in SCHIP?

Researchers from the University of California, San Francisco Institute for Health Policy Studies examined the level of crowd-out occurring in the HFP. Their August 2002 study concluded that up to 8% of new applicants had employment-related insurance within the 3 months prior to enrolling in the HFP. The researchers found that the highest rate of "crowd-out" was in the lower income group (below 200%) and that the single largest reason parents gave for dropping employer-sponsored coverage was that it was unaffordable. More than a quarter of the "crowd-out" group reported paying more than $75 per month.

3. At the time of application, what percent of applicants are found to have insurance?

The HFP does not currently collect data that would indicate the percentage of applicants that have insurance at the time of application. However, the HFP continues to exclude children from enrollment if they have had employer-sponsored health insurance in the last three months prior to their application, unless they meet one of five exceptions listed in question 1. Although the HFP tracks data related to employer-sponsored insurance during time of application, data is not currently available due to vendor transition.

(States with separate child health programs over 200% of FPL must complete question 4)

4. Identify your substitution prevention provisions (waiting periods, etc.).

Please see response to question #3.

(States with a separate child health program between 201% of FFP and 250% of FPL must complete question 5.)

5. Identify the trigger mechanisms or point at which your substitution prevention policy is instituted.

The HFP does not maintain any trigger mechanisms. The HFP substitution prevention policy is continually enforced through program eligibility requirements.

(States with waiting period requirements must complete question 6. This includes states with SCHIP Medicaid expansion programs with section 1115 demonstrations that allow the State to impose a waiting period.)

6. Identify any exceptions to your waiting period requirement.

See response to question #3.

COORDINATION BETWEEN SCHIP AND MEDICAID

(This subsection should be completed by States with a Separate Child Health Program)

1. Do you have the same redetermination procedures to renew eligibility for Medicaid and SCHIP (e.g., the same verification and interview requirements)? Please explain.

The redetermination process for Medicaid is separate from SCHIP. For Medicaid, each county welfare department mails a redetermination form to the applicant one month prior to the child's anniversary date. The form must be returned before the end of the annual redetermination month. If the child is found to be eligible for Medi-Cal, the child will continue to be enrolled in Medi-Cal for an additional twelve months. If the child is not eligible for Medi-Cal, the redetermination form is sent to SPE for HFP eligibility determination as long as there is parental consent. Failure to provide the completed annual redetermination form results in the discontinuance of benefits. However, should the beneficiary complete the annual redetermination required within 30 days of discontinuance, the discontinuance may be rescinded and benefits restored without a break in coverage. Note: This process has not changed since the last reporting period.

For the HFP, the Administrative Vendor sends a preprinted customized Annual Eligibility Review (AER) packet to HFP applicants 60 days prior to the child's anniversary date to verify and update household information and request income documentation.

Although the redetermination process for Medicaid and SCHIP are separate, the income deductions and documentation used by both programs are the same.

2. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes. Have you identified any challenges? If so, please explain.

In Medi-Cal, if a subscriber is determined to be ineligible due to income (too high) at AER, the application is forwarded to HFP. To improve the coordination between the two programs and ensure continuity of care, the State grants an additional one month of Medi-Cal continued coverage while the application is being processed for HFP eligibility.

In the HFP, if a subscriber is determined to be ineligible due to income (too low) at AER and the applicant has requested Medicaid screening, the AER application is forwarded to the county welfare department (CWD) in the county of the child's residence for a Medicaid eligibility determination. In this case, coordination between the two programs and continuity of care is ensured by the State granting two additional months of HFP "bridge coverage" while the application is being processed for Medi-Cal eligibility.

As part of the HFP bridge, California uses a detailed transmittal sheet which accompanies each application it forwards to the CWD. This sheet provides detailed subscriber information such as, the income determination used to screen for no-cost Medi-Cal eligibility for each individual subscriber, the household composition and family relationships, and the unique identification number assigned to each child on the State's Medi-Cal Eligibility Data System (MEDS). The unique Client Index Number (CIN) provides California the ability to track HFP and Medi-Cal applications, enrollment and eligibility

status of children in either program or those being transferred between programs. If the CWD determines that a child is not eligible for no-cost Medi-Cal and may be eligible for the HFP, the transmittal sheet is returned to the Single Point of Entry with the application and with any subsequent documentation for a HFP determination.

3. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

Medi-Cal uses both managed care and fee-for-service providers, and HFP utilizes only managed care providers. There is a significant overlap in the managed care networks for HFP and for Medi-Cal. Of the 27 health plans offered during this reporting period by the HFP, 19 participate in the Medi-Cal program. Approximately 88% of HFP subscribers are enrolled in plans that participate in both programs.

ELIGIBILITY REDETERMINATION AND RETENTION

1. What measures are being taken to retain eligible children in SCHIP? Check all that apply.

X	Follow-up by caseworkers/outreach workers
X	Renewal reminder notices to all families, *specify how many notices and when notified* Subscribers receive an AER Courtesy call 15 days after the AER package was sent to confirm receipt. A reminder postcard is sent after 30 days if package is not received.
	Targeted mailing to selected populations, *specify population*
	Information campaigns
X	Simplification of re-enrollment process, *please describe* Custom pre-printed re-enrollment package in 10 languages
X	Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, *please describe* A survey is conducted during the courtesy call to determine if families have received their AER package, need assistance completing the package or the reason they will not be returning the package for a re-determination. AER courtesy call 15 days after package sent to confirm receipt and a reminder postcard is sent after 30 days if package is not received.
	Other, *please explain*

2. Which of the above measures have been effective? Describe the data source and method used to derive this information.

Currently the HFP does not have data measuring the effectiveness of measures taken to retain eligible children. The HFP has observed a small decrease in the rate of AER packages returned incomplete and a slight increase in the rate of AER packages not returned. However, these changes were too small to be significant.

3. Has your State undertaken an assessment of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured, how many age-out, or how many move?) If so, describe the data source and method used to derive this information.

The HFP assesses and reports a wide variety of enrollment and disenrollment related information on the MRMIB website (www.mrmib.ca.gov) on a monthly basis. This information also details the number and reason children disenroll from the HFP. These reasons include children who do not re-enroll at their AER, not eligible at AER, age out of the program (i.e., reach age 19), and those who obtain other insurance at AER.

During the period of this report, 299,237 new children were enrolled in the HFP. A total of 1,112,781 children were “ever enrolled” in the program. During this same period, 84,264 (0.08% of those children ever enrolled) did not re-enroll in the HFP during their AER. An additional 38,184 (0.03% of

those children ever enrolled) were determined to be no longer eligible during their AER. A total of 16,212 children reached the age of 19 (0.01% of those children ever enrolled).

Although the HFP does not capture all types of private insurance a child may have at their AER, the number of children found to have no-cost Medi-Cal and employer sponsored insurance is reported. A total of 9,661 (0.01% of those children ever enrolled) obtained other health insurance at their AER. This includes 8,332 children enrolled in no-cost Medi-Cal and 1,329 children enrolled in employer sponsored insurance. (Source: Healthy Families Disenrollment Report #9)

Additionally, as recently as 2001 a study was conducted by the National Academy for State Health Policy (NASHP) to learn more about families whose SCHIP coverage lapsed. Results showed that approximately two-thirds (61%) of the families identified in the State's records as "lapsed" gave different accounts of their child's exit from SCHIP. These parents stated their children left for different reasons—reasons that likely make them ineligible for the program.

Of those families with lapsed coverage, 51% stated their child received private insurance, 26% stated they did not re-enroll because a change in income made them ineligible, 13% reported their child received coverage under the Medi-Cal Program, 4% stated their child was no longer eligible because of age and 5% gave other reasons. These numbers for California, when compared to the other states, were similar.

COST SHARING

1. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

California continues to use two surveys of families to assess subscriber children who are disenrolled from the Program due to non-payment of premiums. The first is a postcard survey which is mailed to every applicant after their child(ren)'s disenrollment from the Program for non-payment of premium. This survey includes questions about premiums and the cost of the Program. The applicant is asked to indicate which of the following reasons best describes the reason they did not pay their premium: 1) cannot afford payment, 2) lost invoices, 3) never received invoice, and 4) forgot to pay premium.

The second survey is in conjunction with the non-payment courtesy call initiated by an HFP operator 10 days prior to disenrollment from the Program for non-payment of premium. During this call, the applicant is reminded that a premium payment is necessary in order to keep their child enrolled in the Program. If the applicant indicates they will not be making the payment, the HFP operator attempts to establish the reason why the applicant is not able to make the payment. These reasons include, "Cannot afford the premiums".

From responses to these surveys, the State has found that it is often the case that applicants that want to disenroll their child frequently quit paying their premium rather than providing the HFP with formal notice of disenrollment. Both of these surveys are on a voluntary basis. However, based on both surveys it appears that only a very small percentage of those applicants who do respond are disenrolling from the Program because they cannot afford the cost of the monthly premiums.

2. Has your State undertaken any assessment of the effects of cost sharing on utilization of health services in SCHIP? If so, what have you found?

The State has not conducted an assessment on the effect of cost sharing on utilization of health services. However, many services provided in the HFP do not require copayments. The program was designed with this feature to eliminate a potential barrier to services. Preventative health and dental services and all inpatient services are provided without copayment. Copayments are also not required for services provided to children through the California Children's Services Program and the county mental health departments for children who are Seriously Emotionally Disturbed (SED).

PREMIUM ASSISTANCE PROGRAM(S) UNDER SCHIP STATE PLAN

1. Does your State offer a premium assistance program using title XXI funds under any of the following authorities?

__X__ No, skip to Section IV.

____ Yes, Check all that apply and complete each question for each authority.
____ State plan
____ Family Coverage
____ Section 1115 Demonstration
____ Health Insurance Accountability &Flexibility Demonstration
____ HIPP

2. Briefly describe your program (including current status, progress, difficulties, etc.)

3. What benefit package does the program use?

4. Does the program provide wrap-around coverage for benefits or cost sharing?

5. Identify the total number of children and adults enrolled in the premium assistance program for whom title XXI funds are used during the reporting period (provide the number of adults enrolled in premium assistance even if they were covered incidentally and not via the SCHIP family coverage provision).

_____ Number of adults ever enrolled during the reporting period
_____ Number of children ever enrolled during the reporting period

6. Identify the estimated amount of substitution, if any, that occurred as a result of your premium assistance program. How was this measured?

7. Indicate the effect of your premium assistance program on access to coverage. How was this measured?

8. What do you estimate is the impact of premium assistance on enrollment and retention of children? How was this measured?

SECTION IV: PROGRAM FINANCING FOR STATE PLAN

1. Please complete the following table to provide budget information. Describe in narrative any details of your planned use of funds below. (Note: This reporting period = Federal Fiscal Year 2003 starts 10/1/02 and ends 9/30/03). If you have a combination program you need only submit one budget; programs do not need to be reported separately.)

COST OF APPROVED SCHIP PLAN

Benefit Costs	**Reporting Period**	**Next Fiscal Year**	**Following Fiscal Year**
Insurance payments			
Managed Care	712,029,159	786,400,718	824,595,610
Per member/Per month rate @ # of eligibles			
Fee for Service	128,830,163	197,636,500	215,329,000
Total Benefit Costs	**840,859,322**	**984,037,218**	**1,039,924,610**
(Offsetting beneficiary cost sharing payments)	*(43,072,018)*	*(44,237,153)*	*(44,638,380)*
Net Benefit Costs	**$797,787,304**	**$939,800,064**	**$995,286,231**

Administration Costs			
Personnel			
General Administration	61,226,839	65,351,673	64,160,410
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/Marketing costs	10,282,975	0	0
Other			
Total Administration Costs	**71,509,814**	**65,351,673**	**64,160,410**
10% Administrative Cap (net benefit costs ÷ 9)	**88,643,034**	**104,422,229**	**110,587,359**

Federal Title XXI Share	**565,043,127**	**653,348,629**	**688,640,316**
State Share	**304,253,991**	**351,803,108**	**370,806,324**

TOTAL COSTS OF APPROVED SCHIP PLAN	**$869,297,118**	**$1,005,151,738**	**$1,059,446,641**

2. What were the sources of non-Federal funding used for State match during the reporting period?

- **X** State appropriations
- **X** County/local funds
- ____ Employer contributions
- **X** Foundation grants
- ____ Private donations (such as United Way, sponsorship)
- ____ Other (specify)

SECTION V: 1115 DEMONSTRATION WAIVERS (FINANCED BY SCHIP)

1. If you do not have a Demonstration Waiver financed with SCHIP funds skip to Section VI. If you do, please complete the following table showing whom you provide coverage to.

California has an approved 1115 waiver to provide coverage to parents of children enrolled in Medi-Cal or the HFP. However, the State has not had sufficient State funds to implement the waiver.

	SCHIP Non-HIFA Demonstration Eligibility					HIFA Waiver Demonstration Eligibility				
Children	From	—	% of FPL to	—	% of FPL	From	—	% of FPL to	—	% of FPL
Parents	From	—	% of FPL to	—	% of FPL	From	0%	% of FPL to	200 %**	% of FPL
Childless Adults	From	—	% of FPL to	—	% of FPL	From	—	% of FPL to	—	% of FPL
Pregnant Women	From	—	% of FPL to	—	% of FPL	From	—	% of FPL to	—	% of FPL

****** *Parents are eligible for the HIFA waiver program if a) they have a child enrolled or eligible for Medicaid or SCHIP and b) if the parents are eligible for Medicaid. The implementation of the waiver demonstration has been suspended due to the State's budget constraints.*

2. Identify the total number of children and adults ever enrolled your demonstration SCHIP program during the reporting period.

_____ Number of **children** ever enrolled during the reporting period in the demonstration

_____ Number of **parents** ever enrolled during the reporting period in the demonstration

_____ Number of **pregnant women** ever enrolled during the reporting period in the demonstration

_____ Number of **childless adults** ever enrolled during the reporting period in the demonstration

3. What do you estimate is the impact of your State's SCHIP section 1115 demonstration waiver is on enrollment, retention, and access to care of children?

4. Please complete the following table to provide budget information. Please describe in narrative any details of your planned use of funds. Note: This reporting period (Federal Fiscal Year 2003 starts 10/1/02 and ends 9/30/03).

COST PROJECTIONS OF DEMONSTRATION (SECTION 1115 or HIFA)	Reporting Period	Next Fiscal Year	Following Fiscal Year
Benefit Costs for Demonstration Population #1 (e.g., children)			
Insurance Payments			
Managed care			
per member/per month rate @ # of eligibles			
Fee for Service			
Total Benefit Costs for Waiver Population #1			
Benefit Costs for Demonstration Population #2 (e.g., parents)			
Insurance Payments			
Managed care			
per member/per month rate @ # of eligibles			
Fee for Service			
Total Benefit Costs for Waiver Population #2			
Benefit Costs for Demonstration Population #3 (e.g., pregnant women)			
Insurance Payments			
Managed care			
per member/per month rate @ # of eligibles			
Fee for Service			
Total Benefit Costs for Waiver Population #3			
Total Benefit Costs			
(Offsetting Beneficiary Cost Sharing Payments)			
Net Benefit Costs (Total Benefit Costs - Offsetting Beneficiary Cost Sharing Payments)			
Administration Costs			
Personnel			
General Administration			
Contractors/Brokers *(e.g., enrollment contractors)*			
Claims Processing			
Outreach/Marketing costs			
Other *(specify)*			
Total Administration Costs			
10% Administrative Cap (net benefit costs ÷ 9)			
Federal Title XXI Share			
State Share			
TOTAL COSTS OF DEMONSTRATION			

SECTION VI: PROGRAM CHALLENGES AND ACCOMPLISHMENTS

1. Please provide an overview of what happened in your State during the reporting period as it relates to health care for low income, uninsured children and families. Include a description of the political and fiscal environment in which your State operated.

During the past fiscal year, the State was forced to implement significant budget reductions that affected the administrative support for the program. The State realized a $150 million General Fund savings by eliminating 10.5 staff positions. Outreach funds, which had been eliminated in the 2002 Fiscal Year, were not restored. In the midst of budget reductions, the State has streamlined the eligibility screening and enrollment process by implementing presumptive eligibility for uninsured children receiving services through the State's Children's Health and Disability Prevention (CHDP) Program. Medi-Cal providers participating in the CHDP program can complete an initial HFP/Medi-Cal application form for the patient which is sent to the Single Point of Entry. At Single Point of Entry, the patient is screened for Medi-Cal or HFP eligibility. During the screening process, the patient is given two months of coverage through (HFP/Medi-Cal) until a final determination regarding the patient's eligibility for either program is made. The State is also accepting school lunch applications for the HFP program.

Another significant development in coverage for low income uninsured children and their families is the expansion of the HFP by counties. The State recently enacted law that authorizes the use of the unspent federal allocation for Title XXI as match for county funds to support the county expansion programs. A state plan amendment was submitted March 31, 2003. On May 15, 2003 and June 12, 2003 CMS replied with several questions and requests for clarification on many issues. California anticipates a final response to CMS by March 2004, and anticipates approval by May 2004.

2. During the reporting period, what has been the greatest challenge your program has experienced?

The greatest challenge has been the State's fiscal crisis. The program has enjoyed strong support from stakeholders, the Legislature and the Administration. The program did not experience severe budget reductions as had been the case with other programs. However, the elimination of funds for payment to Enrollment Entities for providing application assistance has had a negative impact on the number of submitted applications that were completed with the assistance of a Certified Applicant Assistant. As a result, the State is witnessing an increase in incomplete applications during the initial enrollment process and at annual eligibility review.

An operational challenge facing the State is the transition of the administrative vendor contract. Recently, the MRMIB re-procured the contract which was awarded to a new vendor and will take effect on January 1, 2004. The previous contractor provided services for the HFP since the beginning of the program in 1998. Since that time, nearly one million children have been ever enrolled in the HFP and currently there are nearly 700,000 children enrolled. The developing and designing of a system, as well as converting data of current and previous subscribers, creates a significant challenge to the State. As of the end of this reporting period, the administrative vendor was on track for a timely implementation of the new contract, meeting all deliverables and transition requirements. The HFP administrative vendor successfully transitioned nearly 700,000 current subscribers and historical records on January 1, 2004.

3. During the reporting period, what accomplishments have been achieved in your program?

In spite of the budget crisis, the program continues to enroll eligible children and pursue innovative ways to increase enrollments for both HFP and no-cost Medi-Cal Programs. Based on 2001 estimates as a baseline, the program has enrolled nearly 86% of children eligible for HFP. In an attempt to reach other eligible children, the State has also accomplished additional streamlining by modifying both the Medi-Cal and Health Families Programs. These changes include the Accelerated Enrollment into no-cost Medi-Cal, the Bridge from Healthy Families to the Medi-Cal Program, and Presumptive Eligibility for the Healthy Families and Medi-Cal Programs through the CHDP Gateway Program.

The Accelerated Enrollment (AE) into no-cost Medi-Cal grants temporary full scope fee-for-service Medi-Cal to most children screened at Single Point of Entry (SPE) who have family income below the HFP level. Those children whose application was forwarded to the local County Welfare Department (CWD) receive a Medi-Cal Beneficiary Identification Card (BIC) 7 to 10 days after they have been screened for

the no-cost Medi-Cal Program. The BIC is sent directly from the Department of Health Services Fiscal Intermediary (i.e., contractor who pays Medi-Cal claims) to the applicant. The child remains on AE until the CWD makes a complete determination of the child's eligibility for Medi-Cal eligibility.

The Bridge from HFP to no-cost Medi-Cal Program grants two additional months of coverage under the HFP for those children whose family income was determined to be below the HFP guidelines at the time of their AER. Those families who authorize their application to be forwarded to Medi-Cal will continue to have coverage to health care while the CWD evaluates them for no-cost Medi-Cal. Those families who do not authorize their application to be forwarded are sent a letter asking them to reconsider Medi-Cal for their child. If the applicant returns the authorization form, their application will also be forwarded. Bridging coverage is for an additional two months and the applicant must continue to pay their monthly premiums.

The CHDP Gateway allows CHDP providers to initiate an application from their program to the Single Point of Entry (SPE). Upon receipt at SPE, the child can be granted presumptive eligibility for either HFP or no-cost Medi-Cal through this process. The majority of children enrolled through the CHDP Gateway process are screened to be eligible for no-cost Medi-Cal.

4. What changes have you made or are planning to make in your SCHIP program during the next fiscal year? Please comment on why the changes are planned.

At this time, the Legislature proposed one change to the program. The Rural Health Demonstration Project (which was designed to enhance access to services for children living in rural areas of the state and for children in migrant and seasonal worker families) had a change of funding source and in the total funds earmarked for these projects. A state plan amendment was submitted in December to reflect this change.

The new administration has proposed an enrollment cap due to the continuing budget crisis. The Legislature has not taken any action on this proposal at the time this report was prepared.

LIST OF ATTACHMENTS
TO THE 2003 FEDERAL ANNUAL REPORT

ATTACHMENT I

Quality Measurement Report – 2002

The major quality objective for the Healthy Families Program (HFP) is to "assure that health services purchased for the program are accessible to enrolled children". To meet this objective, the Managed Risk Medical Insurance Board (MRMIB) uses several tools to monitor access and quality of health care. One of these tools is the health plan quality reports that are submitted annually by participating health plans.

The health plan quality report contains information on a selected set of quality indicators. These indicators were selected based on recommendations from the HFP Quality Accountability Framework, (which was commissioned by the California HealthCare Foundation), the HFP Quality Improvement Work Group and the HFP Advisory Panel. The indicators selected include a set of child-relevant HEDIS® (Health Plan Employer Data and Information Set) measures applicable to the calendar year 2002 and a quality measure that was developed by the California Department of Health Services for the Medi-Cal Managed Care Program.

This report, the Healthy Families Program Quality Measurement Report 2002, summarizes the reports received from participating health plans. The report presents comparable plan information for each quality measure (for which sufficient data was available) and aggregate data for the program.

QUALITY INDICATORS

1) HEDIS®

The National Committee for Quality Assurance's (NCQA) HEDIS® is a nationally recognized tool to evaluate services provided by health plans. Public and private organizations that purchase health care services are principal users of HEDIS®. Many purchasers of health insurance use HEDIS® as a standard for quality measurement.

HEDIS® consists of 56 measures related to effectiveness of care, use of services and access to care. Health plans participating in the HFP were required to report five child-relevant measures. These measures included:

- Childhood Immunization Status
- Well Child Visits in the 3rd, 4th, 5th and 6th Years of Life
- Adolescent Well-Care Visits
- Children's Access to Primary Care Practitioners
- Follow-up After Hospitalization for Mental Illness

NCQA allows health plans to use one of two methods for collecting HEDIS® data. The *administrative method* requires plans to search selected administrative databases (e.g., enrollment, claims, and encounter data systems) for evidence of a service.

The *hybrid method* requires plans to select a random sample of 411 eligible members, and search their administrative databases for information about whether each individual in the

sample received a service. If no information is found, plans are allowed to consult medical records for evidence that services were provided.

Of the measures allowing either data collection option (Childhood Immunizations / Well Child Visits / Adolescent Well Visits), most health plans used the *hybrid method*. Health plans were required to use of the *administrative method* for the Access to Primary Care Provider.

2) 120-DAY INITIAL HEALTH ASSESSMENT

This measure was developed as a pilot measure by the California Department of Health Services and was tested by health plans in 2001. Health plans were required to use the administrative method protocols similar to the protocols for HEDIS®. MRMIB adopted the 120-Day Initial Health Assessment to measure the number of newly enrolled children in the HFP who visited a primary care provider within the first 120 days of their enrollment.

COMPLIANCE AUDIT

MRMIB requires plans to have their quality reports audited by an NCQA certified HEDIS® auditor. The audits ensure the credibility of reported data. All health plans participating in the HFP have complied with the audit requirement.

ANALYSIS OF DATA REPORTED BY PLANS

Each health plan submitted its score or *rate* for the five child relevant HEDIS® measures according to HEDIS® reporting guidelines. These rates were calculated by dividing the number of health plan subscribers who received a particular service (numerator) by the number of subscribers who were eligible to receive the service (denominator). Only those rates that had been certified by a HEDIS® auditor were submitted in the plan reports. The individual plan scores were used to calculate an overall plan average. Health plans that had scores one standard deviation above or below the plan average were identified.

In addition to the plan average, an *aggregate program average* was calculated by dividing members from all health plans who received a particular service by the total number of members in all health plans that were eligible to receive the service. The plan average is compared to *National Results for Selected HEDIS®* measures established by NCQA.

PRESENTATION OF RESULTS

Individual Plan Results

NCQA recommends that scores based on sample sizes of less than 30 members should not be reported. Results from small samples do not withstand the statistical analysis used to determine if the results are due to chance. Plans that had fewer than 30 members in the samples are given a "NM" or Not Meaningful.

Program Results

Each measure is presented in tabular form displaying the score for each category along with the sample size (in parentheses). Results by selected language and ethnic groups are also included.

Information on language preference and ethnicity comes from the member's application. Because some subscribers choose not indicate a language preference or declare an ethnicity on their application, the total sample population may not be equal to the total eligible population sampled.

Healthy Families Program
Quality Measurement Report Overview

The following summary represents the HFP aggregate program scores for the 2000 through 2002 calendar year periods. For comparison, results from NCQA's National Results for Selected HEDIS/CAHPS® Measures and National Medicaid Results for Selected HEDIS® and HEDIS/CAHPS® Measures for *calendar year 2001 are presented*. NCQA calendar year 2002 results *were not* available at time of publication. Current NCQA results can be obtained from the NCQA website at www.ncqa.org.

Table 1 – Overview of HFP Scores and Benchmarks

Measure Description	Healthy Families Program Score 2001 Calendar Year	**Healthy Families Program Score 2002 Calendar Year**	Medi-Cal Managed Care Score 2001 Calendar Year	Medi-Cal Managed Care Score 2002 Calendar Year	NCQA National Average Commercial Results 2001 Calendar Year	NCQA National Average Medicaid Results 2001 Calendar Year
Childhood Immunization Status						
Combination 1*	65%	**72%**	56%	60%	68%	59%
Combination 2*	61%	**69%**	51%	57%	58%	52%
Well Child Visits in the 3rd through 6th Years of Life	60%	**63%**	54%	56%	58%	55%
Adolescent Well-Care Visits	33%	**34%**	26%	27%	38%	32%
Children's Access to Primary Care Practitioners						
Cohort 1 (ages 12 - 24 months)	89%	**91%**	Not Included in Medi-Cal Report	Not Included in Medi-Cal Report	95%	90%
Cohort 2 (ages 25 months - 6 years)	80%	**83%**			86%	70%
Cohort 3 (ages 7 - 11 years)	80%	**82%**			86%	70%
Follow-up After Hospitalization for Mental Illness [(1)]						
within 7 Days	27%	**23%**	Not Included in Medi-Cal Report	Not Included in Medi-Cal Report	51%	32%
within 30 Days	46%	**38%**			73%	52%
120-Day Initial Health Assessment	46%	**48%**	Not Included in Medi-Cal Report	Not Included in Medi-Cal Report	Not Applicable	Not Applicable

* Combination 1 includes age appropriate vaccinations for diphtheria/tetanus/pertussis, polio, measles/ mumps/rubella, H. influenza type B, and Hepatitis B. Combination 2 includes all age appropriate vaccinations in Combination 1 and the chicken pox vaccine.

(1) Total sample size for this measure was 469 subscribers in 2002, 225 subscribers in 2001, and 112 subscribers in 2000. A factor that may make tracking data difficult for this measure is the mental health "carve out" in the HFP. Children who are suspected of being severely emotionally disturbed (SED) are referred to county mental health departments for assessment and treatment. Measure is for adults and children in NCQA.

Childhood Immunization Status

Importance of Measure: It is estimated that one million children in the United States do not receive the necessary vaccinations by age two. Immunizations have proven to be one of the easiest and most effective methods of delivering preventative medicine. Immunizations are the first and foremost line of defense against childhood diseases.

Calculation: This measure is the percentage of children who turned two years old during the measurement year, who were continuously enrolled for 12 months preceding their second birthday and received the following immunizations according to the American Academy of Pediatrics established schedule. Based on the above age and timing criteria, a child may have actually received his or her required immunizations but failed to be included in the measure's numerator.

Combination 1
4 DTP/DTaP (diphtheria/tetanus/pertussis)
3 IPV/OPV (polio)
1 MMR (measles/mumps/rubella)
2 HiB (H. influenzae type b)
3 Hep (Hepatitis B)

Combination 2
Same as Combination 1 plus
1 VZV (Chicken Pox)

2002 Performance: Childhood immunizations have improved consistently over the last three years. Immunizations based on the Combination 2 measure have grown from 57 percent in 2000 to 61 percent in 2001 to the current rate of 69 percent for 2002. *(Changes in overall scores were analyzed and determined to be statistically significant.)* In addition to higher values for the combination rates, scores for the individual antigens have also continued to improve in all categories. Compared to the 2001 NCQA national averages, the HFP continues to perform at levels above both commercial and Medicaid benchmarks.

Of the 18 plans that had sufficient data to report for the 2001 and 2002 reporting period, thirteen (13) plan scores improved at least one percentage point, and five (5) plan scores declined. *(NCQA requires a minimum of 30 observations to consider the sample valid. Five (5) plans did not meet this minimum for both 2001 and 2002 and are identified in Table 4 as "NM" or not meaningful).*

The statistical analysis of selected ethnicities on the following page indicates significant improvement among Latino, White, African American and American Indian/Alaskan Native populations. The Asian/Pacific Islander population was most likely to be immunized, while the White population was least likely to have their required immunizations. Spanish speakers were more likely than English speakers to be immunized. The Asian population measured by either ethnicity or language (Asian/Pacific Islander ethnicities, Chinese, Vietnamese, Korean languages) were generally immunized at a higher rate than the other ethnic and language groups studied.

Table 2: Childhood Immunization Status - Performance Overview

HFP Population Statistics	2000	2001	2002
Number of Plans Reporting	24	23	25 *
Total Sample	2,586	3,943	5,620
Number of Plans Reporting - Methodology	Admin – 2 Hybrid – 22	Admin – 1 Hybrid – 22	Admin – 1 Hybrid – 24
Range of Scores	34% to 75%	35% to 83%	52% to 92%
Average / Median Score	54 % / 53%	60% / 62%	70% / 67%
Aggregate Program Score (Combination 2)	**57%**	**61%**	**69%**

Calendar Year	**Combo 2**	Combo 1	DPT	IPV	MMR	HIB	HEP	VZV
2002	**69%**	72%	83%	89%	92%	85%	85%	88%
2001	**61%**	65%	78%	83%	88%	79%	79%	83%
2000	**57%**	61%	75%	78%	83%	75%	72%	77%

* Note: Although L.A. Care Health Plan reported data and is included in this number and overall calculations, L.A. Care Health Plan no longer participates in HFP and is not included in the Individual Plan Scores graphs.

Table 3: Childhood Immunization Status – Demographic Analysis

Childhood Immunization Status – Combination 2

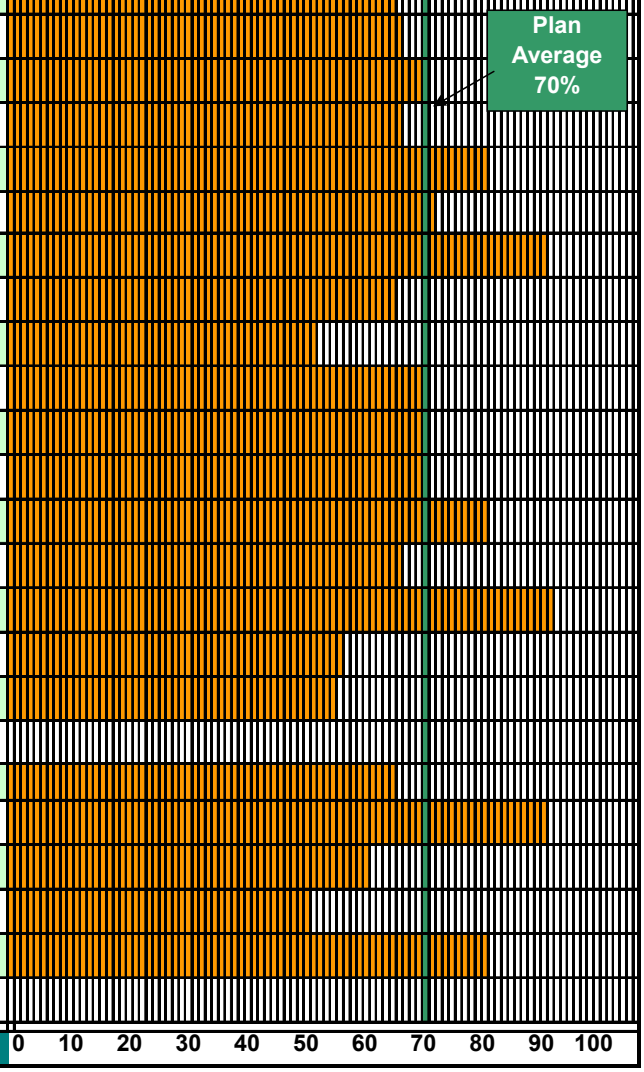
Ethnicity	2001	**2002**
Latino	(1,920) *59%*	(2,813) ***72%***
Asian/Pacific Islander	(335) *72%*	(553) ***77%***
White	(421) *58%*	(627) ***65%***
African American	(56) *54%*	(122) ***75%***
American Indian/ Alaska Native	(9) *33%*	(7) ***100%***

Primary Language of Applicant	2001	**2002**
English	(1,437) *58%*	(2,382) ***69%***
Spanish	(1,393) *61%*	(1,942) ***72%***
Vietnamese	(71) *76%*	(179) ***82%***
Chinese	(125) *66%*	(160) ***74%***
Korean	(50) *80%*	(58) ***76%***

(Number in parentheses indicate the number of children in the eligible sample)

Table 4: Childhood Immunization Status (Combination 2) -- Individual Plan Scores

Health Plan	2000 Score	2001 Score	2002 Score	2002 Percent
				0 10 20 30 40 50 60 70 80 90 100
Aggregate Program Score *	57%	61%	69%	
Alameda Alliance for Health	NM	63%	64%	
Blue Cross - EPO	53%	59%	66%	
Blue Cross - HMO	63%	63%	70%	
Blue Shield - HMO	46%	55%	66%	
CalOptima	48%	76%	81%	
Care 1st Health Plan	NA	NA	73%	
Central Coast Alliance for Health	NM	NM	91% ▲	
Community Health Group	61%	72%	64%	
Community Health Plan	56%	35%	52% ▼	
Contra Costa Health Plan	NM	NM	70%	
Health Net of California	49%	56%	71%	
Health Plan of San Joaquin	56%	57%	70%	
Health Plan of San Mateo	NM	NM	80%	
Inland Empire Health Plan	50%	73%	67%	
Kaiser Permanente	75%	71%	92% ▲	
Kern Family Health Care	50%	66%	57% ▼	
Molina	34%	44%	55% ▼	
Santa Barbara Regional Health	NM	NM	NM	
Santa Clara Family Health Plan	60%	67%	65%	
San Francisco Health Plan	57%	78%	90% ▲	
Sharp Health Plan	39%	54%	61%	
UHP Healthcare	NM	61%	50% ▼	
Universal Care	69%	61%	80%	
Ventura County Health Care Plan	NM	NM	NM	
				0 10 20 30 40 50 60 70 80 90 100



*Blue Shield EPO's sample size to small to report. Not included in report.
NM – Not meaningful. Sample size is too small to meet calculation criteria.
NA – No report. 2002 was the first year Care 1st fully participated.
* Many plans had low sample sizes for calendar year 2000. Please note when comparing changes in individual plan performance.
NOTE: ▲ or ▼ indicate plan score was one or more points above or below the standard deviation from the 2002 plan average.

Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

Importance of Measure: The American Academy of Pediatrics (AAP) recommends annual well-child visits for two to six year olds. Benefits of this measure are detection of potential vision, speech, learning, or other problems that may be prevented by early intervention.

Calculation: This measure describes the percentage of members who were three, four, five, or six years old during the measurement year, who were continuously enrolled in the plan during the measurement year, and who received one or more well-child visit(s) with a primary care provider during the measurement year.

2002 Performance: The tables on pages 8 and 9 describe trends in performance on an aggregate program view as well as individual plan level.

The aggregate HFP scores have continued to improve over the past three years, increasing by 3 percentage points per year with 57% in 2000, 60% in 2001 and 63% in 2002. *(Changes in overall scores were analyzed and determined to be statistically significant).* The HFP performance mirrored the improvements in quality demonstrated by the NCQA national commercial and Medicaid averages, which also improved during the 2001-2002 period. However, the HFP continues to perform at levels above both the 2001 commercial and Medicaid benchmarks.

Individual health plan scores improved steadily with 14 of the 24 plans (60%) improving by at least 1 percentage point, while 7 plans (30%) improved by at least 5 percentage points. Plans that serve the majority of the HFP subscribers (Blue Cross, Health Net, Kaiser, Blue Shield) all showed improvement. Eight plans indicated a decrease in percentage scores for 2002, and one plan remained unchanged.

Based on 2001 and 2002 results, the major trends within the selected demographic analysis are presented in the language and ethnicity of applicant categories. Although scores for this measure have improved marginally for all ethnicities and languages, (with the exception of Korean speakers who demonstrated a drop from 50% to 43%), these improvements are not considered statistically significant. Scores across ethnic groups indicated that Whites were statistically less likely to have a well child visit that either Latinos or Asian/Pacific Islanders. Chinese speakers were more likely to have a visit than either English or Spanish speakers, while Korean speakers were less likely to have received a service compared to all reported languages.

Table 5: Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life Performance Overview

HFP Population Statistics	2000	2001	2002
Number of Plans Reporting	24	24	25*
Total Eligible Population	12,330	14,695	13,776
Number of Plans Reporting - Methodology	Admin – 4 Hybrid – 20	Admin – 3 Hybrid – 21	Admin – 2 Hybrid – 23
Range of Scores	38% to 84%	40% to 74%	29 % to 79%
Average / Median Score	57% / 58%	61% / 63%	62% / 65%
Aggregate Program Score	**57%**	**60%**	**63%**

* Note: Although L.A. Care Health Plan reported data and is included in this number and overall calculations, L.A. Care Health Plan no longer participates in HFP and is not included in the Individual Plan Scores graphs.

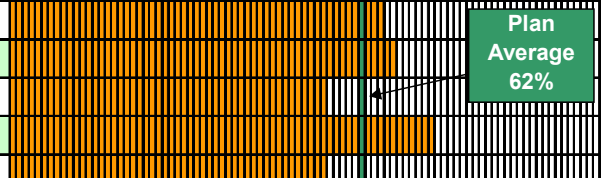
Table 6: Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life--Demographic Analysis

Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life					
Ethnicity			Primary Language of Applicant		
	2001	**2002**		2001	**2002**
Latino	(6,810) *62%*	(6,732) ***63%***	English	(3,585) *59%*	(4,263) ***60%***
Asian/Pacific Islander	(954) *63%*	(1,056) ***64%***	Spanish	(5,380) *62%*	(5,468) ***63%***
White	(966) *54%*	(1,195) ***58%***	Vietnamese	(152) *62%*	(194) ***62%***
African American	(199) *57%*	(284) ***61%***	Chinese	(390) *64%*	(472) ***69%***
American Indian/ Alaska Native	(19) *58%*	(19) ***68%***	Korean	(125) *50%*	(86) ***43%***

(Number in parentheses indicate the number of children in the eligible sample)

Table 7: Well Child Visits in the 3rd, 4th, 5th, and 6th Years of Life - Individual Plan Scores

Health Plan	2000 Score	2001 Score	2002 Score	2002 Percent
				0 10 20 30 40 50 60 70 80 90 100
Aggregate Program Score	57%	60%	63%	
Alameda Alliance for Health	61%	67%	68%	
Blue Cross - EPO	56%	58%	64%	
Blue Cross - HMO	63%	63%	66%	
Blue Shield - HMO	45%	53%	55%	
CalOptima	58%	63%	75% ▲	
Care 1st Health Plan	NA	NA	55%	
Central Coast Alliance for Health	70%	69%	65%	
Community Health Group	66%	68%	65%	
Community Health Plan	40%	43%	35% ▼	
Contra Costa Health Plan	56%	52%	48% ▼	
Health Net of California	49%	54%	61%	
Health Plan of San Joaquin	58%	65%	61%	
Health Plan of San Mateo	44%	69%	69%	
Inland Empire Health Plan	58%	70%	75% ▲	
Kaiser Permanente	59%	64%	65%	
Kern Family Health Care	55%	66%	70%	
Molina	39%	58%	68%	
Santa Barbara Regional Health	61%	74%	69%	
Santa Clara Family Health Plan	72%	73%	65%	
San Francisco Health Plan	84%	74%	79% ▲	
Sharp Health Plan	62%	63%	67%	
UHP Healthcare	62%	40%	29% ▼	
Universal Care	65%	57%	66%	
Ventura County Health Care Plan	49%	57%	58%	
				0 10 20 30 40 50 60 70 80 90 100



*Blue Shield EPO's sample size to small to report. Not included in report.
NA - No report. 2002 was the first year Care 1st fully participated.
NOTE: ▲ or ▼ indicate plan score was one or more points above or below the standard deviation from the 2002 plan average.

Adolescent Well-Care Visits

Importance of Measure: Detection of changes in physical, social and emotional health status during this transitional period in a child's life is of great importance. The American Medical Association and the American Academy of Pediatrics stress the need for yearly visits in this population.

Calculation: This measure describes the percentage of members, ages 12 through 21 years old during the measurement year, who were continuously enrolled in the plan during the measurement year, and who received at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year. Because the HFP only covers children through their 19th birthday, the reports from the plans were based on children between the ages of 12 and 19.

2002 Performance: The aggregate program score improved by 1 percentage point to 34 percent. This score is above the 2001 NCQA national average for Medicaid plans and below the NCQA national average for commercial plans. Statistically, the aggregate percentage score differential between the HFP, Medicaid and Commercial plans may be considered nominal. Of the 24 plans reporting, 15 scores improved, with 6 plans improving by at least 5 percentage points, and 8 scores declining by at least 1 percentage point.

Table 8 on page 11 shows a decrease in 2001 for the total sample even though the HFP population continued to grow significantly during the 2000 to 2001 period. The 2001 decrease is due to a larger number of plans employing the *hybrid method* of data collection. As described on page 2 of this report, this method allows plans to use a random sampling method for scoring. Unless plans have comprehensive administrative data systems, rates based on the *hybrid method* are generally higher, but require more effort and are more costly than the *administrative* method. For 2002, the majority of plans continued to use the hybrid method and the increase in the sample population is reflected accordingly.

The demographic variables show significant improvements in English and Spanish speakers from 2001 to 2001. In addition, Latinos showed significant improvement in scoring from the prior year. Changes in all other language and ethnic categories were not deemed statistically significant. Comparisons between ethnic groups showed Whites being less likely to have a visit than the other groups analyzed and Asian/Pacific Islanders have a higher rate that Latinos. Chinese speakers show a significantly higher rate of visits than both English and Spanish speakers. As with the Well child visits, Korean speakers show significantly lower scores as compared to the other reported groups.

Table 8: Adolescent Well-Care Visits -- Performance Overview

HFP Population Statistics	2000	2001	2002
Number of Plans Reporting	24	24	25*
Total Sample	33,011	17,841	21,976
Number of Plans Reporting - Methodology	Admin – 6 Hybrid – 18	Admin – 3 Hybrid – 21	Admin – 3 Hybrid – 22
Range of Scores	13% to 47%	16% to 53%	12% to 49%
Average / Median Score	29% / 29%	32% / 33%	33% / 34%
Aggregate Program Score	**28%**	**33%**	**34%**

* Note: Although L.A. Care Health Plan reported data and is included in this number and overall calculations, L.A. Care Health Plan no longer participates in HFP and is not included in the Individual Plan Scores graphs.

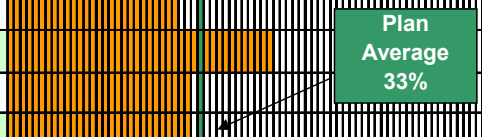
Table 9: Adolescent Well-Care Visits – Demographic Analysis

Adolescent Well-Care Visits					
Ethnicity			Primary Language of Applicant		
	2001	**2002**		2001	**2002**
Latino	(6,815) *31%*	(10,207) ***35%***	English	(4,623) *30%*	(8,263) ***34%***
Asian/Pacific Islander	(1,521) *34%*	(1,747) ***38%***	Spanish	(5,335) *31%*	(8,028) ***35%***
White	(1,480) *30%*	(2,707) ***32%***	Vietnamese	(255) *35%*	(273) ***40%***
African American	(402) *33%*	(785) ***38%***	Chinese	(734) *38%*	(838) ***41%***
American Indian/ Alaska Native	(43) *30%*	(52) ***29%***	Korean	(575) *31%*	(217) ***29%***

(Number in parentheses indicate the number of children in the eligible sample)

Table 10: Adolescent Well-Care Visits- Individual Plan Scores

Health Plan	2000 Score	2001 Score	2002 Score	2002 Percent
				0 10 20 30 40 50 60 70 80 90 100
Aggregate Program Score	27%	33%	34%	
Alameda Alliance for Health	30%	34%	44% ▲	
Blue Cross - EPO	25%	31%	29%	
Blue Cross - HMO	27%	35%	34%	
Blue Shield - HMO	23%	24%	27%	
CalOptima	31%	38%	47% ▲	
Care 1st Health Plan	NA	NA	31%	
Central Coast Alliance for Health	16%	32%	31%	
Community Health Group	38%	32%	34%	
Community Health Plan	20%	18%	20% ▼	
Contra Costa Health Plan	28%	24%	15% ▼	
Health Net of California	25%	27%	35%	
Health Plan of San Joaquin	28%	24%	28%	
Health Plan of San Mateo	26%	35%	48% ▲	
Inland Empire Health Plan	41%	41%	43%	
Kaiser Permanente	31%	32%	35%	
Kern Family Health Care	34%	32%	35%	
Molina	29%	39%	47% ▲	
Santa Barbara Regional Health	40%	36%	34%	
Santa Clara Family Health Plan	45%	36%	33%	
San Francisco Health Plan	47%	40%	49% ▲	
Sharp Health Plan	29%	34%	35%	
UHP Healthcare	22%	16%	12% ▼	
Universal Care	33%	35%	39%	
Ventura County Health Care Plan	19%	27%	22% ▼	
				0 10 20 30 40 50 60 70 80 90 100



*Blue Shield EPO's sample size to small to report. Not included in report.
NA – No report. 2002 was the first year Care 1st fully participated.
NOTE: ▲ or ▼ indicate plan score was one or more points above or below the standard deviation from the 2002 plan average.

Children's Access to Primary Care Practitioners

Importance of Measure: Childhood access to primary care practitioners is positively associated with successful completion of recommended immunizations and identification and treatment of childhood conditions at early stages of disease.

Calculation: This measure describes children in three different age groups who had a visit with a plan primary care practitioner.

Children age 12 months through 24 months who were continuously enrolled during the measurement year and had a visit with a primary care practitioner during the measurement year.

In the Healthy Families Program, children in this age range constitute a small portion of the program's total enrollment. This is because children in this age range are only eligible if they are in families with incomes between 200% and 250% of Federal income guidelines.

Children age 25 months through 6 years who were continuously enrolled during the measurement year and had a visit with a primary care practitioner during the measurement year.

Children age 7 years through 11 years who were continuously enrolled during the measurement and the calendar year preceding the measurement year who had a visit with a primary care practitioner during the measurement year or the year preceding the measurement year.

Children are allowed one gap of up to 45 days during each year of continuous enrollment.

2002 Performance: This Access/Availability measure continues to show improvement during the 2002 reporting period. The overall aggregate program scores for Cohort 1 (12 to 24 months), Cohort 2 (25 months to 6 years) and Cohort 3 (Age 7 to 11 years) improved by 4, 5 and 3 percentage points, respectively. Trending plans from 2000 to 2002, these scores represent a 10 percentage point improvement for Cohort 2, and a 9 percentage point improvement for Cohort 3. Cohort 1's lesser recognized improvement during the same three-year period may be attributed to the relatively low sample of HFP subscribers in this category. *(Changes in overall score for all cohorts were analyzed and determined to be statistically significant).*

With respect to individual plan scores, 7 plans had scores for Cohort 1 that improved from the 2001 period. CalOptima, Health Plan of San Francisco had scores that improved from 2001 to 2002 by at least 10 percentage points. Over half the plans submitting meaningful data for Cohort 2 (55%) had improved their performance. Blue Shield HMO, Health Net, San Francisco Health Plan and UHP Healthcare registered improvements ranging from 10 to 26 percentage points from the 2001 period. Approximately 32 percent (7 plans), improved their scores by at least 5 percentage points. With respect to Cohort 3, 7 plans had improved scores, with Health Net, San Francisco Health Plan and UHP showing the greatest improvement.

Selected demographic analysis for all three cohorts indicate statistically significant improvements for most ethnic and language groups, the exception being African Americans in cohort 1 and American Indian/Alaskan Natives in Cohort 1 and Indian/Alaskan Natives in Cohort 2.

From 2001 to 2002, Cohort 2 experienced the greatest increase in the Asian/Pacific Islander (8 percentage points) and Latino (7 percentage points) in the ethnicity demographic category. In the primary language

demographic category, Cohort 1 experienced a 19 percentage point increase in the Vietnamese and a 10 percent increase in the Chinese demographic. In Cohorts 2 and 3, 10 percentage point increases were indicated for the Vietnamese (Cohort 2) and Korean (Cohort 3) in the language demographic category.

From 2001 to 2002, in both Cohort 1 and Cohort 2 in the ethnicity demographic category, the greatest meaningful increases were in Asian/Pacific Islander demographic (13 and 8 percentage points, respectively), followed by the Latino demographic with 6 and 7 percentage points in the same cohorts. The Cohort 3 African American category reflects an increase of 9 percentage points. A cross sectional review of these different ethnic groups reveals that the White population was significantly more likely to score higher than the other groups. This observation was similar in all cohorts.

In the primary language demographic category, Cohort 1 experienced a 19 percentage point increase in the Vietnamese and a 10 percent increase in the Chinese demographic. In Cohorts 2 and 3, 10 percentage point increases were indicated for Vietnamese (Cohort 2) and Korean (Cohort 3) languages. In comparing language groups, the only statistically significant observation was the lower scores for Chinese speakers relative to all other categories.

Table 11: Children's Access to Primary Care Practitioners - Cohort 1 (Ages 12 to 24 month) – Performance Overview

HFP Population Statistics *Cohort 1 Age 12 to 24 months*	2000	2001	2002
Number of Plans Reporting	23	23	24
Total Sample	1,500	5,222	7,488
Number of Plans Reporting - Methodology	Admin – 23 Hybrid – 0	Admin – 23 Hybrid – 0	Admin – 24 Hybrid – 0
Range of Scores	56% to 98%	72% to 100%	83% to 100%
Average / Median Score	82% / 84%	89% / 93%	93% / 93%
Aggregate Program Score	**87%**	**89%**	**93%**

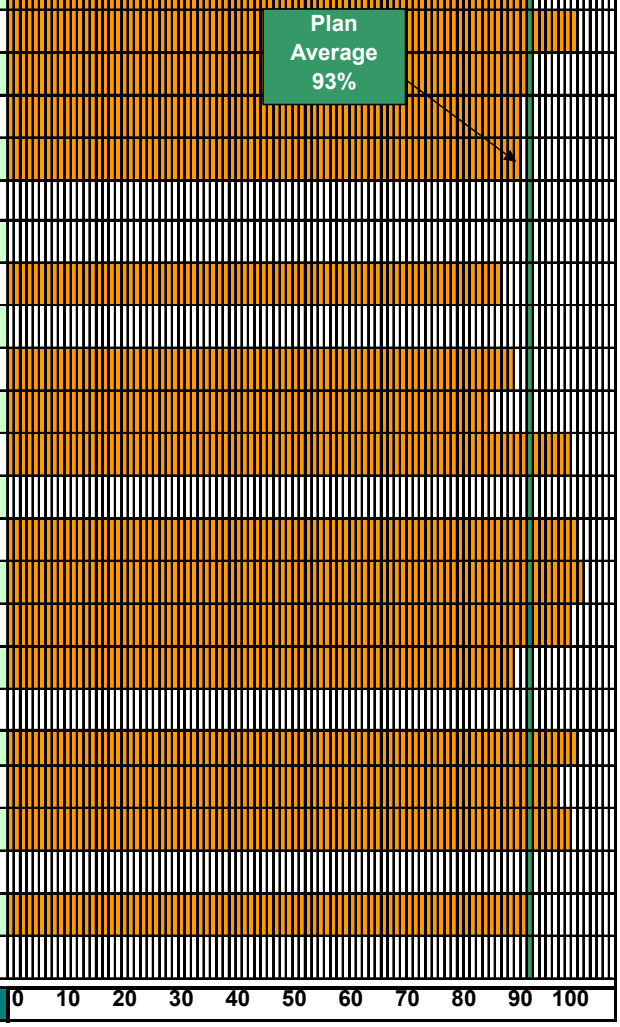
Table 12: Children's Access to Primary Care Practitioners - Cohort 1 (Ages 12 to 24 months) – Demographic Analysis

Children's Access to Primary Care Practitioners — Cohort 1					
Ethnicity			Primary Language of Applicant		
	2001	**2002**		2001	**2002**
Latino	(2,495) *88%*	(3,377) ***94%***	English	(2,329) *89%*	(3,496) ***94%***
Asian/Pacific Islander	(645) *81%*	(783) ***94%***	Spanish	(1,607) *88%*	(2,181) ***95%***
White	(610) *92%*	(990) ***96%***	Vietnamese	(131) *79%*	(227) ***98%***
African American	(98) *87%*	(133) ***92%***	Chinese	(158) *79%*	(246) ***89%***
American Indian/ Alaska Native	(8) *88%*	(16) ***100%***	Korean	(112) *90%*	(113) ***90%***

(Number in parentheses indicate the number of children in the eligible sample)

Table 13: Children's Access to Primary Care Practitioners - Cohort 1 (Ages 12 to 24 months) - Individual Plan Scores

Health Plan	2000 Score	2001 Score	2002 Score	2002 Percent
				0 10 20 30 40 50 60 70 80 90 100
Aggregate Program Score	87%	89%	93%	
Alameda Alliance for Health	NM	93%	93%	
Blue Cross - EPO	98%	99%	99% ▲	
Blue Cross - HMO	90%	91%	93%	
Blue Shield - HMO	72%	78%	89%	
CalOptima	84%	80%	90%	
Care 1st Health Plan	NA	NA	NM	
Central Coast Alliance for Health	NM	NM	NM	
Community Health Group	77%	95%	85% ▼	
Community Health Plan	NM	NM	NM	
Contra Costa Health Plan	NM	93%	88%	
Health Net of California	66%	72%	83% ▼	
Health Plan of San Joaquin	NM	97%	97%	
Health Plan of San Mateo	NM	NM	NM	
Inland Empire Health Plan	80%	95%	99% ▲	
Kaiser Permanente	99%	99%	100% ▲	
Kern Family Health Care	NM	97%	97%	
Molina	NM	84%	89%	
Santa Barbara Regional Health	NM	NM	NM	
Santa Clara Family Health Plan	NM	100%	98%	
San Francisco Health Plan	NM	83%	96%	
Sharp Health Plan	89%	93%	97%	
UHP Healthcare	NM	NM	NM	
Universal Care	NM	92%	93%	
Ventura County Health Care Plan	NM	NM	NM	
				0 10 20 30 40 50 60 70 80 90 100



*Blue Shield EPO's sample size to small to report. Not included in report.
NM – Not meaningful. Sample size is too small to meet calculation criteria.
NA – No report. 2002 was the first year Care 1st fully participated.
NOTE: ▲ or ▼ indicate plan score was one or more points above or below the standard deviation from the 2002 plan average.

Table 14: Children's Access to Primary Care Practitioners - Cohort 2 (Ages 25 months to 6 years) – Performance Overview

HFP Population Statistics – *Cohort 2 Age 25 months to 6 years*	2000	2001	2002
Number of Plans Reporting	24	23	24
Total Sample	41,608	72,667	93,509
Number of Plans Reporting - Methodology	Admin – 23 Hybrid – 0	Admin – 23 Hybrid – 0	Admin – 24 Hybrid – 0
Range of Scores	25% to 92%	41% to 92%	51% to 94%
Average / Median Score	71% / 72%	80% / 85%	83% / 86%
Aggregate Average Program Score	**75%**	**80%**	**85%**

Table 15: Children's Access to Primary Care Practitioners - Cohort 2 Ages 25 months to 6 years – Demographic Analysis

Children's Access to Primary Care Practitioners — Cohort 2

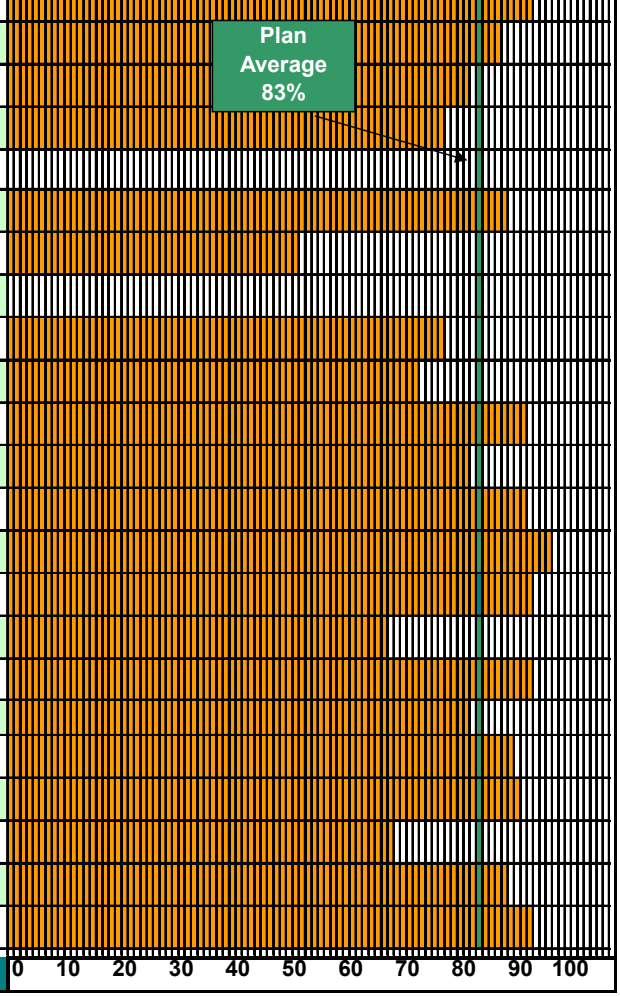
Ethnicity	2001	**2002**
Latino	(40,316) *79%*	(47,312) ***86%***
Asian/Pacific Islander	(5,756) *76%*	(8,522) ***84%***
White	(5,354) *82%*	(10,379) ***87%***
African American	(1,149) *77%*	(1,686) ***83%***
American Indian/ Alaska Native	(213) *79%*	(240) ***79%***

Primary Language of Applicant	2001	**2002**
English	(27,364) *80%*	(34,772) ***86%***
Spanish	(30,344) *79%*	35,304) ***86%***
Vietnamese	(986) *75%*	(1,678) ***85%***
Chinese	(3,170) *74%*	(3,368) ***82%***
Korean	(1,277) *79%*	(1,468) ***84%***

(Number in parentheses indicate the number of children in the eligible sample)

Table 16: Children's Access to Primary Care Practitioners - Cohort 2 (Ages 25 months to 6 years) - Individual Plan Scores

Health Plan	2000 Score	2001 Score	2002 Score	2002 Percent
				0 10 20 30 40 50 60 70 80 90 100
Aggregate Program Score	75%	80%	85%	
Alameda Alliance for Health	64%	86%	91%	
Blue Cross - EPO	91%	92%	91%	
Blue Cross - HMO	84%	84%	84%	
Blue Shield - HMO	63%	70%	81%	
CalOptima	68%	74%	76%	
Care 1st Health Plan	NA	NA	NM	
Central Coast Alliance for Health	92%	90%	86%	
Community Health Group	81%	88%	51% ▼	
Community Health Plan	41%	50%	NM	
Contra Costa Health Plan	85%	84%	77%	
Health Net of California	51%	60%	72%	
Health Plan of San Joaquin	88%	92%	92%	
Health Plan of San Mateo	58%	78%	81%	
Inland Empire Health Plan	51%	83%	89%	
Kaiser Permanente	92%	94%	94%	
Kern Family Health Care	86%	91%	90%	
Molina	50%	64%	70% ▼	
Santa Barbara Regional Health	90%	93%	91%	
Santa Clara Family Health Plan	82%	89%	82%	
San Francisco Health Plan	86%	74%	88%	
Sharp Health Plan	84%	86%	90%	
UHP Healthcare	25%	41%	67% ▼	
Universal Care	83%	85%	86%	
Ventura County Health Care Plan	88%	89%	92%	
				0 10 20 30 40 50 60 70 80 90 100



*Blue Shield EPO's sample size to small to report. Not included in report.
NM – Not meaningful. Sample size is too small to meet calculation criteria.
NA – No report. 2002 was the first year Care 1st fully participated.
NOTE: ▲ or ▼ indicate plan score was one or more points above or below the standard deviation from the 2002 plan average.

Table 17: Children's Access to Primary Care Practitioners - Cohort 3 (Ages 7 to 11 years) - Performance Overview

HFP Population Statistics – *Cohort 3 Age 7 to 11 years*	**2000**	**2001**	**2002**
Number of Plans Reporting	23	23	24
Total Eligible Population	14,217	51,250	92,391
Number of Plans Reporting - Methodology	Admin – 23 Hybrid – 0	Admin – 23 Hybrid – 0	Admin – 24 Hybrid – 0
Range of Scores	24% - 94%	46% to 94%	41% to 93%
Average / Median Score	67% / 70%	80% / 85%	81% / 84%
Aggregate Program Score	**74%**	**80%**	**83%**

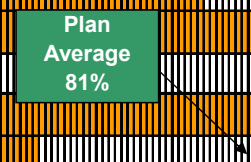
Table 18: Children's Access to Primary Care Practitioners - Cohort 3 Ages 7 to 11 years – Demographic Analysis

Children's Access to Primary Care Practitioners — Cohort 3					
Ethnicity			Primary Language of Applicant		
	2001	**2002**		2001	**2002**
Latino	(20,813) *79%*	(48,183) ***84%***	English	(13,687) *81%*	(32,734) ***84%***
Asian/Pacific Islander	(4,854) *75%*	(8,984) ***81%***	Spanish	(16,274) *78%*	38,501) ***84%***
White	(4,575) *84%*	(10,875) ***86%***	Vietnamese	(354) *74%*	(1,027) ***82%***
African American	(650) *76%*	(1,625) ***85%***	Chinese	(2,853) *75%*	(4,349) ***79%***
American Indian/ Alaska Native	(78) *83%*	(278) ***80%***	Korean	(888) *73%*	(1,857) ***83%***

(Number in parentheses indicate the number of children in the eligible sample)

Table 19: Children's Access to Primary Care Practitioners - Cohort 3 Ages 7 to 11 years – Individual Plan Scores

Health Plan	2000 Score	2001 Score	2002 Score	2002 Percent
				0 10 20 30 40 50 60 70 80 90 100
Aggregate Program Score	74%	80%	83%	
Alameda Alliance for Health	79%	87%	90%	
Blue Cross - EPO	76%	90%	87%	
Blue Cross - HMO	70%	84%	81%	
Blue Shield - HMO	61%	70%	70%	
CalOptima	62%	74%	80%	
Care 1st Health Plan	NA	NA	NM	
Central Coast Alliance for Health	NM	94%	81%	
Community Health Group	79%	86%	41% ▼	
Community Health Plan	38%	51%	NM	
Contra Costa Health Plan	NM	81%	72%	
Health Net of California	61%	63%	73%	
Health Plan of San Joaquin	85%	83%	82%	
Health Plan of San Mateo	47%	91%	86%	
Inland Empire Health Plan	50%	80%	88%	
Kaiser Permanente	94%	94%	93%	
Kern Family Health Care	69%	88%	89%	
Molina	61%	66%	73%	
Santa Barbara Regional Health	78%	90%	92%	
Santa Clara Family Health Plan	76%	86%	83%	
San Francisco Health Plan	84%	75%	88%	
Sharp Health Plan	89%	88%	90%	
UHP Healthcare	30%	46%	67% ▼	
Universal Care	84%	85%	84%	
Ventura County Health Care Plan	90%	90%	89%	
				0 10 20 30 40 50 60 70 80 90 100



*Blue Shield EPO's sample size to small to report. Not included in report.
NM – Not meaningful. Sample size is too small to meet calculation criteria.
NA – No report. 2002 was the first year Care 1st fully participated.
NOTE: ▲ or ▼ indicate plan score was one or more points above or below the standard deviation from the 2002 plan average.

Follow-up After Hospitalization for Mental Illness

Importance of Measure: According to the National Institute for Mental Health, a significant percentage of individuals experience some form of mental illness, yet only a small percentage are actually diagnosed. For many children, hospitalization often represents the first introduction to mental health services. Regular follow-up therapy is an important component in assuring adequate treatment for patients diagnosed and hospitalized for mental illness.

Calculation: This measure calculates the percentage of subscribers age six and older who were hospitalized for treatment of selected mental health disorders who were continuously enrolled for 30 days after discharge (without gaps) and were seen on an ambulatory basis or were in day/night treatment with a mental health provider. Two scores are generated: 1) the percentage of subscribers who had an ambulatory or day/night mental health visit within *30 days* of hospital discharge, and 2) the percentage of subscribers who had an ambulatory or day/night mental health visit within *7 days* of hospital discharge.

2002 Performance: A factor that continues to hinder accurate tracking of meaningful data for this measure is the mental health "carve out" in the HFP. Children who are suspected of being severely emotionally disturbed (SED) are referred to county mental health departments for assessment and treatment. A health plan's ability to track the necessary information for this measure requires an effective exchange of information with the counties about every health plan's HFP enrollee with SED.

This fact limited the total sample size for this measure to 112 subscribers in 2000 and 225 subscribers in 2001. NCQA recommends that individual plan data not be reported when there is a sample size less than 30. In 2002 the sample size increased to 469 subscribers; however, only three out of 25 participating plans met the minimum sample size. Therefore, plan comparisons are not included in this report.

Table 20: Follow-up After Hospitalization for Mental Illness – Performance Overview

HFP Population Statistics Follow-up After Hospitalization for Mental Illness	2000	2001	2002
Number of Plans Reporting	11	11	18
Total Eligible Population	112	225	469
Number of Plans Reporting Methodology	Admin – 3 Hybrid – 8	Admin – 3 Hybrid – 8	Admin – 18 Hybrid – 0
Range of Scores	Insufficient data	Insufficient data	Insufficient data
Average / Median Score	Insufficient data	Insufficient data	Insufficient data
Aggregate Program Score 7 Days 30 Days	 **21%** **34%**	 **27%** **46%**	 **23%** **38%**

120-Day Initial Health Assessment

Importance of Measure: In addition to the HEDIS® measures, MRMIB required participating health plans to provide an additional measure identified as the *120-Day Initial Health Assessment.* This measure was initially developed as a voluntary pilot project through the California Department of Health Services and tested by selected health plans. It is intended to measure whether the primary care practitioner adequately assesses the subscriber's health status and assumes responsibility for the effective management of the subscriber's health care needs.

Calculation: The measure calculates the percentage of subscribers who enrolled during the reporting year and received an initial health assessment within their first 120 days of enrollment. Subscribers eligible for this measure must be two years of age or older upon their effective enrollment date and continuously enrolled for at least 120 days immediately following the effective enrollment date, with no gaps in enrollment.

Data Collection: The 120-Day Initial Health Assessment measure required the use of the *Administrative Method* of data collection for 2001 and 2002. Prior to 2001, plans had the choice of the *Administrative or Hybrid methods* of data collection.

2002 Performance: This measure encompasses the largest sample of children of all measures presented in this report, with over 298,000 subscribers sampled during the 2002 reporting period. Analysis of 2000 to 2002 data indicates overall program aggregate scores steadily improved from 43 percent in 2000 to 46 percent in 2001 to 48 percent in 2002. *(Changes in overall scores were analyzed and determined to be statistically significant).*

Over the three years, results showed 75 percent of plans realized improved scores of at least 2 percentage points. However, 7 plans (33%) showed a decline of 5 or more percentage points from 2001 to 2002.

Almost one-half of plans (41%) reporting meaningful data improved their 2001 score by at least 2 percentage points in 2002, while 5 plans (Blue Shield HMO, Health Net, Inland Empire Health Plan, Molina and San Francisco Health Plan) had improvements of at least 8 percentage points.

Selected demographic analysis for this measure remains relatively consistent across categories, with a general increase of between 1 and 7 percentage points. In the ethnicity demographic, statistically significant improvements were registered by the Latino, Asian Pacific Islander and African American groups, while all language groups experienced improvements deemed significant. Within the ethnic categories, African Americans were less likely to receive their 120 day IHA while Whites were more likely to receive one than the other groups studied. Chinese speakers were less likely to receive this visit that the other groups, while English speakers were more likely to receive this service.

No NCQA benchmarks exist for this measure.

Table 21: 120 Day Initial Health Assessment – Performance Overview

HFP Population Statistics	2000	2001	2002
Number of Plans Reporting	24	24	22
Total Eligible Population	200,011	224,886	298,277
Number of Plans Reporting - Methodology	Admin- 24 Hybrid - 0	Admin - 24 Hybrid - 0	Admin - 22 Hybrid - 0
Range of Scores	14% to 62%	22% to 76%	12% to 71%
Average / Median Score	39% / 39%	44% / 44%	44% / 45%
Aggregate Program Score	**43%**	**46%**	**48%**

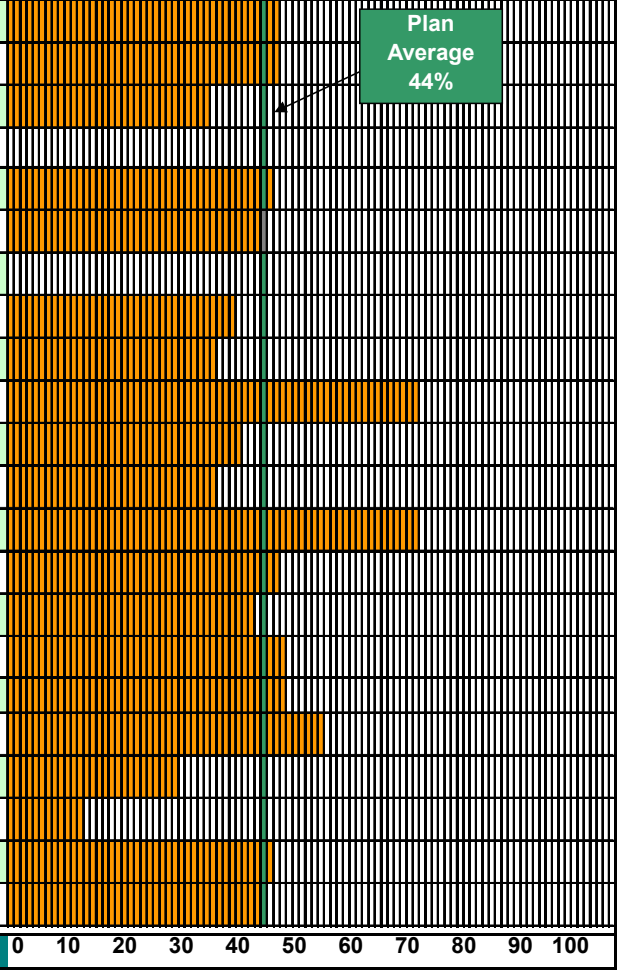
Table 22: 120 Day Initial Health Assessment – Demographic Analysis

120-Day Initial Health Assessment					
Ethnicity			Primary Language of Applicant		
	2001	**2002**		2001	**2002**
Latino	(124,698) *44%*	(132,873) ***49%***	English	(95,586) *48%*	(116,645) ***51%***
Asian/Pacific Islander	(18,398) *45%*	(19,246) ***48%***	Spanish	(99,346) *43%*	(99,579) ***48%***
White	(31,462) *53%*	(41,075) ***54%***	Vietnamese	(3,750) *42%*	(3,230) ***49%***
African American	(6,229) *41%*	(6,983) ***44%***	Chinese	(6,076) *42%*	(4,349) ***44%***
American Indian/ Alaska Native	(938) *47%*	(1,222) ***51%***	Korean	(4,355) *47%*	(4,363) ***52%***

(Number in parentheses indicate the number of children in the eligible sample)

Table 23: 120 Day Initial Health Assessment – Individual Plan Scores

Health Plan	2000 Score	2001 Score	2002 Score	2002 Percent
				0 10 20 30 40 50 60 70 80 90 100
Aggregate Program Score	43%	46%	48%	
Alameda Alliance for Health	35%	45%	42%	
Blue Cross - EPO	59%	61%	56%	
Blue Cross - HMO	56%	58%	46%	
Blue Shield - HMO	22%	38%	47%	
CalOptima	28%	36%	34%	
Care 1st Health Plan	NA	NA	NM	
Central Coast Alliance for Health	33%	40%	45%	
Community Health Group	39%	42%	44%	
Community Health Plan	25%	22%	NM	
Contra Costa Health Plan	34%	44%	39%	
Health Net of California	21%	28%	36%	
Health Plan of San Joaquin	62%	60%	70% ▲	
Health Plan of San Mateo	49%	76%	40%	
Inland Empire Health Plan	28%	20%	36%	
Kaiser Permanente	57%	67%	71% ▲	
Kern Family Health Care	48%	50%	46%	
Molina	25%	33%	42%	
Santa Barbara Regional Health	52%	54%	48%	
Santa Clara Family Health Plan	51%	54%	49%	
San Francisco Health Plan	41%	39%	53%	
Sharp Health Plan	51%	27%	29%	
UHP Healthcare	19%	32%	12% ▼	
Universal Care	41%	44%	45%	
Ventura County Health Care Plan	39%	44%	43%	
				0 10 20 30 40 50 60 70 80 90 100



*Blue Shield EPO's sample size to small to report. Not included in report.
NM – Not meaningful. Sample size is too small to meet calculation criteria.
NA – No report. 2002 was the first year Care 1st fully participated.
NOTE: ▲ or ▼ indicate plan score was one or more points above or below the standard deviation from the 2002 plan average.

Appendix A -- Scoring Summary By Measure

▲ = Indicates Score 1 Standard Deviation Above the Mean

▼ = Indicates Score 1 Standard Deviation Below the Mean

Measure

PLAN	Child Immun	Well Child 4,5 & 6	Adol Well Child	PCP Access Cohort 1	PCP Access Cohort 2	PCP Access Cohort 3	120-Day IHA
Alameda Alliance for Health			▲				
Blue Cross EPO				▲			
Blue Cross HMO							
Blue Shield HMO							
CalOPTIMA		▲	▲				
Care1st Health Plan							
Central Coast Alliance for Health	▲						
Community Health Group				▼	▼	▼	
Community Health Plan	▼	▼	▼				
Contra Costa Health Plan		▼	▼				
Health Net				▼			
Health Plan of San Joaquin							▲
Health Plan of San Mateo			▲				
Inland Empire Health Plan		▲		▲			
Kaiser Permanente	▲			▲			▲
Kern Health Systems (Kern Family Health Care)	▼						
Molina	▼		▲		▼		
Santa Barbara Regional Health Authority							
Santa Clara Family Health Plan							
San Francisco Health Plan	▲	▲	▲				
Sharp Health Plan							
UHP HealthCare	▼	▼	▼		▼	▼	▼
Universal Care							
Ventura County Health Care Plan			▼				

Endnotes

i. HEDIS® is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care organizations.

NCQA is an independent, not-for-profit organization dedicated to measuring the quality of America's health care.

ii. Report prepared by Benefits and Quality Monitoring, Managed Risk Medical Insurance Board. For questions, please call Lorraine Brown at (916) 324-4695 or e-mail lbrown@mrmib.ca.gov.

ATTACHMENT II

2003 Report of Consumer Survey of Health Plans

In the Fall of 2002, the Managed Risk Medical Insurance Board (MRMIB), through a contract with an independent vendor (Datastat, Inc.), conducted the third annual consumer survey for the Healthy Families Program (HFP). The survey was conducted to assess the satisfaction and experience families were having with participating health plans and to provide existing and potential HFP applicants with information about their health plan options. This report summarizes the results from the survey.

SURVEY METHODOLOGY

The survey was conducted using the Child Medicaid version of the Consumer Assessment of Health Plan Survey (CAHPS®) 2.0H instrument which contains 72 questions pertaining to nine aspects of care. The aspects of care that were covered in the survey include access to care, customer service, communication of providers, and quality and satisfaction of health plan services and health care received. The responses to the survey questions were summarized into four global ratings and five composite scores. The global ratings included ratings of health care, health plan, regular doctor or nurse, and specialist. The composite scores addressed getting needed care, getting care quickly, how well doctors communicate, helpfulness and courteousness of doctor's office staff and customer service.

The survey was conducted in five languages--English, Spanish, and three Asian languages, Vietnamese, Korean and Chinese. (See endnote.)

THE SURVEY SAMPLE

A random sample of families was selected according to NCQA (National Committee for Quality Assurance) protocols for conducting the survey. Families with children ages 12 years and

younger, who had been continuously enrolled in the plan for at least six months as of June 30, 2002 were selected from each participating health plan. Twenty-six health plans were included in the survey. The target sample size for health plans was 1,050. Nineteen plans had sufficient HFP enrollment to provide the target sample. For the seven plans that did not have sufficient enrollment, all subscribers who met the criteria were surveyed. Table 1 shows the number of families who were selected for the survey for each participating health plan.

Table 1 – Families Surveyed From Each Health Plan

Health Plan	Number of families surveyed
Alameda Alliance for Health	1,050
Blue Cross – EPO	1,050
Blue Cross – HMO	1,050
Blue Shield – EPO	524
Blue Shield – HMO	1,050
CalOptima	1,050
Care 1st Health Plan	1,050
Central Coast Alliance for Health	505
Community Health Group	1,050
Community Health Plan	1,050
Contra Costa Health Plan	692
Health Net	1,050
Health Plan of San Joaquin	1,050
Health Plan of San Mateo	469
Inland Empire Health Plan	1,050
Kaiser Permanente	1,050
Kern Family Health Care	1,050
LA Care Health Plan	1,050
Molina	1,050
San Francisco Health Plan	1,050
Santa Barbara Regional Health Authority	513
Santa Clara Family Health Plan	1,050
Sharp Health Plan	1,050
UHP Healthcare	612

Universal Care	1,050
Ventura County Health Plan	1,039
Total Program	**24,304**

Families selected for the survey received the survey in English, and either Spanish, Chinese, Korean or Vietnamese if one of these languages was designated as the primary language on the families' HFP application. Table 2 outlines the distribution of the survey instruments mailed in each language for each health plan.

Table 2 – Distribution of Surveys in Each Language Group by Health Plan

Health Plan	Total	E	S	C	K	V
Alameda Alliance	1,050	356	448	202	11	33
Blue Cross - EPO	1,050	614	419	9	6	2
Blue Cross - HMO	1,050	464	446	73	53	14
Blue Shield - EPO	524	414	101	5	1	3
Blue Shield - HMO	1,050	600	309	65	60	16
CalOptima	1,050	170	728	5	33	114
Care 1st Health Plan	1,050	267	770	6	6	1
Central Coast Alliance for Hlth.	505	132	368	3	2	0
Community Health Group	1,050	293	740	3	1	13
Community Health Plan	1,050	246	733	55	4	12
Contra Costa Health Plan	692	196	490	2	2	2
Health Net	1,050	526	441	61	7	15
Health Plan of San Joaquin	1,050	498	534	13	0	5
Health Plan of San Mateo	469	118	347	3	1	0
Inland Empire Health Plan	1,050	407	636	0	1	6
Kaiser Permanente	1,050	612	407	20	4	7
Kern Family Health Care	1,050	466	578	0	3	3
LA Care Health Plan	1,050	240	768	32	8	2
Molina	1,050	291	758	0	1	0
San Francisco Health Plan	1,050	213	199	635	1	2
Santa Barbara Regional Health Auth.	513	146	367	0	0	0
Santa Clara Family Health Plan	1,050	223	642	17	1	167
Sharp Health Plan	1,050	534	491	9	2	14
UHP Healthcare	612	208	329	27	42	6
Universal Care	1,050	235	796	1	1	17
Ventura County	1,039	227	811	0	0	1
Health Plan						

E= English S=Spanish C=Chinese K=Korean V=Vietnamese

THE SURVEY PROCESS

The survey was conducted using the Medicaid CAHPS® 2.0H survey protocol. Datastat conducted the survey over an 8-week period using a mixed-mode (telephone and mail) five-step protocol between the months of September and December 2002. The five-step protocol consisted of a pre-notification mailing and initial survey mailing, a reminder postcard to all respondents and a second survey mailing and second reminder postcard to non-respondents. Telephone follow-up was conducted for non-respondents in English and Spanish only. (The protocol for conducting the telephone follow-up in the Asian languages was not available for this survey.) The timeline for the survey is presented in Table 3.

Table 3 – Survey Timeline

Pre-notification letter mailed	September 17, 2002
First questionnaire with cover letter mailed	September 23, 2002
Reminder postcard to non-respondents mailed	September 30, 2002
Second questionnaire and letter mailed to non-respondents	October 21, 2002
Second reminder postcard mailed to non-respondents	October 28, 2002
Telephone follow-up is conducted for non-respondents	November 4, 2002
Survey ends	December 2, 2002

The pre-notification and follow-up correspondences were developed based on recommended samples from the CAHPS®2.0H protocol.

SURVEY RESULTS

Response Rates

The response rate for the 2002 survey (65.1%) was slightly higher than the response rate for the 2001 survey (62.4%) and represents the highest response rate to date. The response rates were calculated by eliminating those who did not meet the requirements for the survey. The number of usable surveys included only those surveys that

were completed according to CAHPS® 2.0H protocol for conducting the survey. For this survey, 1,395 surveys were eliminated from the 24,304 surveys mailed, resulting in a net usable 22,909 surveys. Of these surveys, a total of 14,920 surveys were returned. Table 4 shows the response rates for each participating health plan.

Table 4 -- Response Rates for Each Health Plan

Health Plan	Number of families surveyed	Number of Usable Surveys	Number of usable responses	Response Rate
Alameda Alliance for Health	1,050	990	632	63.8%
Blue Cross EPO	1,050	1,005	716	71.2%
Blue Cross HMO	1,050	982	659	67.1%
Blue Shield EPO	524	481	288	59.9%
Blue Shield HMO	1,050	986	628	63.7%
CalOPTIMA	1,050	987	644	65.2%
Care 1st Health Plan	1,050	987	623	63.1%
Central Coast Alliance for Health	505	475	326	68.6%
Community Health Group	1,050	994	679	68.3%
Community Health Plan	1,050	950	589	62.0%
Contra Costa Health Plan	692	661	437	66.1%
Health Net	1,050	998	662	66.3%
Health Plan of San Joaquin	1,050	994	657	66.1%
Health Plan of San Mateo	469	435	278	63.9%
Inland Empire Health Plan	1,050	986	655	66.4%
Kaiser Permanente	1,050	1,004	666	66.3%
Kern Family Health Plan	1,050	983	620	63.1%
L.A. Care Health Plan	1,050	996	647	65.0%
Molina	1,050	1,002	633	63.2%
San Francisco Health Plan	1,050	987	537	54.4%
Santa Barbara Regional Health Auth.	513	474	364	76.8%
Santa Clara Family Health Plan	1,050	991	619	62.5%
Sharp Health Plan	1,050	999	654	65.5%
UHP Healthcare	612	577	365	63.3%
Universal Care	1,050	995	629	63.2%
Ventura County Health Plan	1,039	990	713	72.0%
Total	**24,304**	**22,909**	**14,920**	**65.1%**

Summary of Responses

The responses to the survey were summarized into four rating and five composite questions. Where responses indicate a positive experience (as defined separately below for rating and composite scores) they are characterized as an "achievement score". Charts displaying the survey results by health plan are presented beginning on page 6 of this report.

Rating Questions Responses: For the four rating questions, a 10-point scale was used to assess overall experience with health plans, providers, specialists and health care. NCQA has recommended two ways to present survey results. The charts on pages 6 through 9 present the plan scores in both ways. The solid bar shows the percent of families rating the overall experience with health plans, personal providers, specialists and health care an 8, 9 or 10. The hollow bars show the percentage of families rating the overall experience with health plans, primary providers, specialists and health care a 9 or 10. While both types of achievement scores are presented in the charts on pages 6 through 9, the narrative refers only to scores based on 8, 9,and 10 ratings allowing

comparisons between scores from the 2002 and 2001 surveys.

Individual plan scores for the 2002 survey are compared with the overall program score in 2002 and 2001 and a *benchmark*. This benchmark is based on the highest score achieved by a participating health plan with a minimum of 75 responses.

The results of the survey indicated that at least 80 percent of families rated their health care, health plan, personal doctor (or nurse) and specialist an 8, 9 or 10. The highest score achieved for the program was in the rating of health plan at 87 percent. The lowest rating score for the program was approximately 80 percent for the rating of the specialist. Of the scores achieved by individual plans, 92 percent was the highest score achieved for overall rating of a health plan. The lowest score obtained was 71 percent for the overall rating of personal doctor or nurse.

The percentage of families rating their health plan an 8, 9 or 10 ***increased*** from 2001 to 2002 from 85 percent to 87 percent, respectively. Other year to year differences were not significantly different.

Composite Score Results: For the composite scores, the composite question is grouped with other questions that relate to the same broad domain of performance. For example, "*Getting Care Quickly*" includes questions about getting advice by phone, about how soon appointments were scheduled, and about time spent waiting in the doctor's office. The achievement score for these questions is determined by the percentage of families who respond positively to each question. A response is considered positive if the answers are "not a problem" for the questions comprising the *Getting Needed Care* and *Customer Service* composites, and "usually" and "always" for the *Getting Care Quickly*, *How Well Doctors Communicate*, and *Courteous and Helpful Office Staff* composites.

The survey questions that make up the composite cores are listed below.

Getting Needed Care

- Able to get a personal doctor or nurse for child you are happy with
- Able to get a referral to a specialist for child
- Able to get the care for child believed necessary
- No problems with delays in child's health care while awaiting approval

Getting Care Quickly

- Usually or always got help of advice needed of child
- Child usually or always got an appointment for routine care as soon as wanted
- Child usually or always got needed care for an illness/injury as soon as wanted
- Child never or sometimes waited more than 15 minutes in the doctor's office or clinic

How Well Doctor's Communicate

- Doctors usually or always listened carefully
- Doctors usually or always explained things in an understandable way
- Doctors usually or always showed respect
- Doctors usually or always spent enough time with child

Courteous and Helpful Office Staff

- Usually or always treated with courtesy and respect by office staff
- Office staff usually or always helpful

Customer Service

- Able to find or understand information in written materials
- Able to get help needed when you called child's health plan's customer service

For most of the composite ratings, at least 80 percent of families responded positively. The composite rating with the highest percentage of families responding positively was for *How Well Doctor's Communicate* questions, at approximately 88 percent. The composite rating with the lowest percentage of families responding positively was *Getting Care Quickly* at approximately 70 percent.

A comparison of composite scores from the 2001 and 2002 survey did not yield any significant differences.

With respect to individual health plan scores, the highest composite score achieved was at 94 percent and was for the *How Well Doctor's Communicate and Courteous and Helpful Staff* composites. The lowest score achieved by a health plan was approximately 63 percent for the *Getting Care Quickly* composite.

SURVEY RESULTS FOR PARTICIPATING HEALTH PLANS

The results for each participating health plan is presented in the charts beginning on the next page. Plans that have achievement scores significantly higher or lower than the program score are indicated by a "+" or "-" next to their scores.

Based on an oversampling of families who received the survey in Chinese, Vietnamese and Korean in 2000, it appears that families responding in these languages rate the various factors less favorably than families responding in English and Spanish. This difference in responses among language groups may affect the scores of participating health plans with a large number of subscribers whose primary language is one of the Asian languages.

CONCLUSION

Families continue to have positive experiences with their health care their children receive in HFP. 81% give high ratings to health care received from HFP. Additionally, response rates for the consumer survey of health plans continue to be high. This suggests that parents and caregivers of children enrolled in the HFP are very interested in the care their children receive in the program. All scores increased from 2001 to 2002, although these increases were not large enough to be considered statistically significant.

Comparative consumer survey data for programs like Healthy Families (or State Child Health Insurance Programs) do not appear to be available. However, data on children's health coverage from the National CAHPS® Benchmarking Database Project show that results received for the HFP were not substantially different from results presented in the 2002 CAHPS® Benchmarking Database report for Medicaid and commercial plans. With respect to results from the rating questions, HFP had a higher result for rating of health plan (72 percent versus 51and 57 percent for commercial and Medicaid programs respectively). For the ratings of health care, personal doctor or nurse and specialists, results for the HFP were similar to that of the commercial and Medicaid programs. The above ratings are based on the percentage of families rating plans either a 9 and 10 on a scale of 0 to 10.

With respect to the composite questions, HFP results were higher for *Customer Service* (83 percent, versus 70 and 67 percent for commercial and Medicaid respectively). HFP results were lower for *Getting Care Quickly* (70 versus 86 and 83 percent for commercial and Medicaid). For the remaining three composites (*Getting Needed Care, How Well Doctor's Communicate, and Courteous and Helpful Office Staff*) HFP results were in the range of scores seen for commercial and Medicaid programs.

The data obtained from this survey provides plans and MRMIB with an opportunity to uncover areas of success and areas needing improvement. MRMIB has begun developing a framework for addressing plan performance using clinical quality data (e.g., HEDIS), which when completed, will be adapted for consumer survey results. At present, health plans are provided with detailed information about their results which they have used to initiate changes in the delivery of services.

One area that MRMIB continues to explore is the differences in survey responses among the five language groups. RAND has received results from previous HFP health surveys for analysis. The completion of RAND's analysis is expected by the end of the year.

ATTACHMENT III

2003 Report of Consumer Survey of Dental Plans

In the fall of 2002, the Managed Risk Medical Insurance Board (MRMIB), through a contract with an independent vendor (DataStat, Inc.), conducted a consumer survey of dental plans participating in the Healthy Families Program (HFP). This survey was the second annual consumer survey of dental plans using the instrument developed by members of the CAHPS® consortium. The results presented in this report are the only results of this type available in the country. To date, no other publicly funded insurance program has used the D-CAHPS® survey to evaluate dental services provided.

The survey was conducted to assess the satisfaction and experience families were having with participating dental plans and to provide existing and potential HFP applicants with information about their dental plan options. This report summarizes the results from the survey.

SURVEY METHODOLOGY

The instrument used for the survey was developed by the CAHPS® consortium which modified it for the Healthy Families Program. The instrument was based on the Child Medicaid version of the Consumer Assessment of Health Plan Survey (CAHPS®) 2.0H which contains 70 questions pertaining to nine aspects of care. The aspects of care that were covered in the survey include access to care, customer service, communication of providers, and quality and satisfaction of dental plan services and dental care received. The responses to the survey questions were summarized into four global ratings and five composite scores. The global ratings included ratings of dental care, dental plan, regular dentists and specialists. The composite scores addressed getting needed dental care, getting needed care quickly, how well doctors communicate, helpfulness and courteousness of doctor's office staff and customer service.

THE SURVEY SAMPLE

DataStat selected a random sample of families using a modified version of the NCQA (National Committee for Quality Assurance) protocols for conducting the CAHPS® 2.0H survey. Families with children between the ages of 4 and 18 years of June 30, 2002 and who were continuously enrolled in their dental plan for at least 12 months were eligible to participate in the survey. Families with children under the age of 4 were not selected for the survey because of the likelihood that these children would not have seen a dentist.

Of the families who were eligible for the survey, only those families who did not receive a previous HFP consumer survey for health plans were selected. This was to ensure that no family was burdened with having to complete a health and dental survey in the same year. The number of families selected for the survey from each dental plan participating in the HFP was 1,050. A total of 5,250 surveys were distributed. Table 1 shows the number of families who were selected for the survey for each participating dental plan.

Table 1 – Families Surveyed From Each Dental Plan

Dental Plan	Number of families surveyed
Access Dental	1,050
Delta Dental	1,050
Health Net Dental	1,050
Premier Access	1,050
Universal Care Dental	1,050
Total Program	**5,250**

Families selected for the survey received the survey in English, and either Spanish, Chinese, Korean or Vietnamese if one of these languages was designated as the primary language on the

families' HFP application. Table 2 outlines the distribution of the survey instruments mailed in each language for each health plan.

Table 2 – Distribution of Surveys in Each Language Group by Dental Plan

Dental Plan	Total	E	S	C	K	V
Access Dental	1,050	421	548	32	36	13
Delta Dental	1,050	477	470	59	26	18
Health Net Dental	1,050	393	584	48	19	6
Premier Access	1,050	704	342	1	1	2
Universal Care Dental	1,050	385	611	28	10	16
Total	5,250	2,380	2,555	168	92	55

E= English S=Spanish C=Chinese
K=Korean V=Vietnamese

THE SURVEY PROCESS

The survey was conducted using a protocol that was based on the protocol for the Medicaid CAHPS® 2.0H survey. Datastat conducted the survey over an eight week period using a single mode (mail-only) 5 step protocol between the months of September and December. This consisted of a pre-notification mailing, an initial survey mailing, a reminder postcard to all respondents, a second survey mailing and a second reminder postcard to non-respondents. The pre-notification and follow-up correspondences were developed based on recommended samples from the CAHPS®2.0H protocol.

Table 3 – Survey Timeline

Pre-notification letters mailed:	September 17, 2002
1st mailing of reminder packets:	September 23,2002
2nd mailing of survey packets:	October 21, 2002
2nd mailing of reminder postcards:	October 28, 2002
Survey ends:	December 2, 2002

Because the D-CAHPS® survey is still being developed, the protocol for the telephone follow-up was not available for this survey.

SURVEY RESULTS

Response Rates

The response rate for the survey was 46.4 percent. This response rate exceeded the target response rate of 45 percent. The response rates were calculated by eliminating from the surveys that were returned, those who did not meet the requirements for the survey. The number of usable surveys included only those surveys that were completed according to CAHPS® 2.0H protocol for conducting the survey. For this survey, 443 surveys were eliminated from the 5,250 surveys mailed, resulting in a net usable 4,807 surveys. Of these surveys, only 2,232 surveys were considered "usable" based on the CAHPS® 2.0H survey protocol.

Below are the response rates for each participating dental plan.

Table 4 -- Response Rates for Each Dental Plan

Dental Plan	Surveys mailed	Usable surveys	Usable responses	Response Rate
Access Dental	1,050	973	441	45.3%
Delta Dental	1,050	982	496	50.5%
Health Net Dental	1,050	981	402	41.0%
Premier Access	1,050	882	452	51.2%
Universal Care	1,050	989	441	44.6%
Total	**5,250**	**4,807**	**2,232**	**46.4%**

Although Health Net Dental's response rate was less than 45%, there were at least 75 responses per question which is adequate for producing valid results.

Summary of Responses

The responses to the survey were summarized into four rating and five composite questions. Responses that indicate a positive experience are characterized in achievement scores as identified below. Charts displaying the survey results by dental plan are presented beginning on page 5 of this report.

Rating Questions Responses: For the four rating questions, a 10-point scale was used to assess overall experience with dental plans, providers, specialists and dental care. NCQA has recommended two ways to calculate the survey data. The charts on pages 5 through 8 present the plan scores in both ways. The solid bar shows the percentage of families rating the overall experience with dental plans, dental care,

providers and specialist an 8, 9, or 10. The hollow bars show the percentage of families rating the overall experience with dental plans, dental care, providers and specialists a 9 or 10. While both types of achievement scores are presented in the charts, the narrative refers only to scores based on the 8, 9, and 10 ratings, allowing scores from the 2001 and 2002 survey reports to be compared.

Individual plan scores for the 2002 survey are compared with the overall program score in 2002 and a *benchmark*. This benchmark is based on the highest score achieved by a participating dental plan with a minimum of 75 responses.

The results of the survey indicated that between 65 to 75 percent of families rated their dental care, dental plan, personal dentist and specialist an 8, 9 or 10. The highest score achieved for the program overall was in the rating of dental care specialist at 75 percent. The lowest score achieved for the program overall was the 65 percent score for the rating of dental plan.

Of the scores achieved by individual plans, 85 percent was the highest score achieved for overall rating of dental specialist. The lowest score obtained was approximately 53 percent for the overall rating of dental care.

Composite Score Results: For the survey, the composite question is grouped with other questions that relate to the same broad domain of performance. For example, the domain, "Getting Dental Care Quickly" includes questions about getting advice by phone, about how soon appointments were scheduled and about time spent waiting in the dentist's office. The achievement score for these questions is determined by the percentage of families who respond positively to each question. A response in considered positive if the answers are "not a problem" for the questions comprising the "Getting Needed Dental Care" and "Customer Service" composites, and "usually" and always" for the "Getting Care Quickly", "How Well Doctors Communicate" and "Courteous and Helpful Office Staff" composites. The survey questions that make up the composites scores are listed below.

Getting Needed Dental Care

- Able to get your child a dental office or clinic you are happy with
- Able to get a referral to a specialist for child
- Able to get the care believed necessary for child
- No problems with delays in child's dental care while awaiting approval

Getting Dental Care Quickly

- Usually or always got help of advice needed for child
- Child usually or always got an appointment to fill or treat a cavity as soon as wanted
- Child usually or always got an appointment for routine care as soon as wanted
- Child usually or always got needed care for mouth pain or dental problem as soon as wanted
- Child never or sometimes waited more than 15 minutes in dentist's office or clinic

How Well Dentists Communicate

- Dentists usually or always listened carefully
- Never or sometimes had a hard time speaking with or understanding the dentist because you spoke differently
- Dentists usually or always explained things in an understandable way
- Child usually or always got an interpreter when needed.
- Child never or sometimes had a hard time speaking with or understanding dentist because he or she spoke different languages
- Dentists usually or always explained things to child in an understandable way
- Dentists usually or always spent enough time with child

Courteous and Helpful Office Staff

- Usually or always treated with courtesy and respect by office staff

- Office staff usually or always helpful

Customer Service

- Able to find or understand information in written materials
- Able to get help needed when you called child's dental plan's customer service

 Scores ranged from approximately 53 to 81 percent of families having a positive experience with the five domains of dental services as described above. The highest score achieved for the program overall was in the rating of *How Well Dentists Communicate* at approximately 81 percent. The lowest program overall score was for C*ustomer Service* at 51 percent.

 With respect to individual dental plan scores, the highest composite score achieved was approximately 94 percent for the *Courteous and Helpful Office Staff* composite. The lowest score achieved by a dental plan was approximately 44 percent for the *Customer Service* composite.

SURVEY RESULTS FOR PARTICIPATING DENTAL PLANS

The results for each participating dental plan are presented in the following charts. Plans that have achievement scores significantly higher or lower than the program score are indicated by a "+" or "-" next to their scores.

CONCLUSIONS

The information presented in this report represents a ground-breaking effort to understand the experience families have with dental plans. Because the D-CAHPS® survey instrument is new, comparative data is not yet available.

The results of the survey show significant variations in the scores between the dental plan types. The open access EPO dental plans had higher scores than the dental DMO plans. Further study is required to understand the dramatic differences in these results.

The 2002 and 2003 results obtained for the HFP are being analyzed by members of the CAHPS® consortium. Their analysis will result in further refinement of the D-CAHPS® instrument.

Acknowledgements

Prepared by Cristal Milberger, Benefits Specialist,

Assisted by Lorraine Brown, Deputy Director, Benefits and Quality Monitoring

ATTACHMENT IV

Open Enrollment 2003

Summary Report

Open Enrollment 2003 Summary Report

Subscribers with option to change plans at 2003 OE **Total = 663,845**	Subscribers Who Voluntarily Changed Plans	% of Total	Subscribers Who Were Required* to Change Plans	% of Total	Sub-Total Subscribers That Changed During OE	% of Total	Total Subscribers That Changed During OE	% of Total
Subscribers changing only Health Plans:	**11,671**	**1.76%**	**20,445**	**3.08%**	**32,116**	**4.84%**	**36,903**	**5.56%**
Subscribers changing only Dental Plans:	**6,636**	**1.00%**	**1**	**0.00%**	**6,637**	**1.00%**	**11,424**	**1.72%**
Subscribers changing both Health and Dental Plans:	**2,775**	**0.42%**	**2,012**	**0.30%**	**4,787**	**0.72%**		

*Indicates the plan(s) a subscriber was enrolled in would no longer be available in their zip code beginning July 1st.

Open Enrollment Historical Data

	1999	% of Total	2000	% of Total	2001	% of Total	2002	% of Total	2003	% of Total
Subscribers Changing Health Plans	3,827	3%	10,326	4%	14,566	3%	16,485	3%	36,903	6%
Subscribers Changing Dental Plans	3,875	3%	8,005	3%	22,031	5%	12,142	2%	11,424	2%
Subscribers With Option To Change Plans at OE **TOTAL=**	113,083		293,978		434,346		555,890		663,845	

Data includes voluntary and required transfer requests

Open Enrollment 2003 - Satisfaction Survey

- Over 12,000 responses were received to the Satisfaction Survey

On a scale of 1 – 5 (5 meaning extremely satisfied; 1 meaning not satisfied at all) on average respondents indicated they were *Satisfied* with the services received from their Health Plan (3.0) and Vision Plan (3.8) but *Not Very Satisfied* with the services received from their Dental Plan (2.4).

Reasons Why Plan Transfers Were Requested

- 6,176 responded to Health Plan survey and 4,649 responded to Dental Plan survey

Top Reasons

Health Plan Changes

1. Problem getting a Doctor I'm happy with
2. Not being able to see a doctor when the need is urgent
3. Not satisfied with medical care received

Dental Plan Changes

1. Problem getting a Dentist I'm happy with
2. Appointments to see the dentist have to be made too long in advance
3. Not satisfied with the dental care received

HEALTHY FAMILIES

Customer Satifaction Survey Historical Data

Open Enrollment 1999-2003

Survey Question	Response	Extremely Satisfied (5)	Very Satisfied (4)	Satisfied (3)	Not Very Satisfied (2)	Not at all (1)	Average Score
Question 1 "How satisfied are you with the level of service you have received from your Health Plan?"							
1999	*	*	*	*	*	*	2.3
2000	*	*	*	*	*	*	3.4
2001	4780	*	*	*	*	*	3.0
2002	4742	569 (12%)	863(%18)	1683 (35%)	1212 (26%)	415 (9%)	3.0
2003	6785	793(12%)	1288(19%)	2568(38%)	1661(24%)	475(7%)	3.0
Question 4 "How satisfied are you with the level of service you have received from your medical group/clinic and the doctors and nurses who work there?"							
1999	*	*	*	*	*	*	2.3
2000	*	*	*	*	*	*	3.4
2001	4559	*	*	*	*	*	3.1
2002	4584	671 (15%)	871(19%)	1598 (35%)	1010 (22%)	434 (9%)	3.1
2003	6550	841(13%)	1266(19%)	2323(35%)	1541(24%)	579(9%)	3.0
Question 2 "How satisfied are you with the level of service you have received from your Dental Plan?"							
1999	*	*	*	*	*	*	1.5
2000	*	*	*	*	*	*	3.0
2001	6895	*	*	*	*	*	2.2
2002	4683	299 (6%)	384 (8%)	1045 (22%)	1603 (34%)	1352 (29%)	2.3
2003	4859	325(7%)	461(9%)	1172(24%)	1590(33%)	1311(27%)	2.4
Question 3 "How satisfied are you with the level of service you have received from your Vision Plan?"							
1999	Question Not Included On Survey						
2000	Question Not Included On Survey						
2001	7973	*	*	*	*	*	3.7
2002	9743	2857 (29%)	2800 (29%)	3526 (36%)	368 (4%)	192 (2%)	3.7
2003	12796	3618(28%)	3935(31%)	4609(36%)	406(3%)	228(2%)	3.8

Legend

* Data is not available

1999-2000 data included voluntary and required transfer requests

2001-2003 data included voluntary transfer requests only (except Vision Question)

HEALTHY FAMILIES

Health Plan Change Reasons Historical Data

Open Enrollment 1999-2003

Note - Applicant may have indicated more than one reason. Data includes voluntary and required transfer requests.

	1999		2000		2001		2002		2003	
Surveys Returned each OE Year	641		3,160		6,400		5,899		6,176	
Responses for each OE Year	494		3,586		7,413		11,457		22,247	
Reason	**Number of Responses**	**% of Cases**	**Number of Responses**	**% of Cases**	**Number of Responses**	**% of Cases**	**Number of Responses**	**% of Cases**	**Number of Responses**	**% of Cases**
Problem getting a Doctor I'm happy with	*125	25%	*719	20%	987	13%	1,555	14%	2,843	13%
Problem getting a specialist when I need one	*36	7%	*279	8%	520	7%	923	8%	1,771	8%
Problem getting care that I or my doctor believed to be necessary	**	**	**	**	357	5%	604	5%	1,018	5%
Not satisfied with medical care received	*75	15%	*719	20%	716	10%	1,090	10%	2,068	9%
Primary care doctor left the plan	63	13%	201	6%	403	5%	610	5%	1,243	6%
Appointments to see the doctor have to be made too long in advance	63	13%	591	16%	651	9%	1,153	10%	1,827	8%
2 weeks	**	**	**	**	**	**	**	**	725	3%
3 weeks	**	**	**	**	**	**	**	**	400	2%
4 or more weeks	**	**	**	**	**	**	**	**	702	3%
Not being able to see a doctor when the need is urgent	**	**	**	**	723	10%	1,191	10%	2,457	11%
Not satisfied with the hours or days a primary care doctor's office is open	*18	4%	*382	11%	350	5%	479	4%	1,351	6%
Problem getting help or advise during regular office hours	**	**	**	**	358	5%	616	5%	1,257	6%
I need an interpreter but doctor's office does not have one	*29	6%	*124	3%	120	2%	172	2%	265	1%
Doctor's office is too far away	67	14%	440	12%	507	7%	707	6%	1,298	6%
1 to 5 miles	**	**	**	**	74	1%	81	1%	219	1%
6 to 10 miles	**	**	**	**	136	2%	210	2%	384	2%
10 miles or more	**	**	**	**	293	4%	416	4%	695	3%
Children are discriminated against because they are enrolled in Healthy Families.	18	4%	131	4%	132	2%	204	2%	316	1%
Other:	**	**	**	**	1,086	15%	1,446	13%	4,533	20%
Total	494	100%	3,586	100%	7,413	100%	11,457	100%	22,247	100%

Legend

* The wording of the question has changed. The meaning is generally the same.

** The question was not included in that year's survey.

Dental Plan Change Reasons Historical Data

Open Enrollment 1999-2003

Note - Applicant may have indicated more than one reason. Data includes voluntary and required transfer requests.

	1999		2000		2001		2002		2003	
Surveys Returned each OE Year	740		2,949		7,587		6,096		4,649	
Response for each OE Year	473		1,737		15,985		13,338		11,152	
Reason	**Number of Responses**	**% of Cases**	**Number of Responses**	**% of Cases**	**Number of Responses**	**% of Cases**	**Number of Responses**	**% of Cases**	**Number of Responses**	**% of Cases**
Problem getting a dentist I'm happy with	*233	49%	*757	44%	2,343	15%	2,031	15%	1,900	17%
Problem getting a specialty dentist when I need one	*77	16%	*362	21%	1,083	7%	948	7%	853	8%
Problem getting care that I or my dentist believed to be necessary	**	**	**	**	669	4%	625	5%	614	6%
Not satisfied with dental care received	163	34%	*618	36%	1,624	10%	1,469	11%	1,440	13%
Primary care dentist left the plan	**	**	**	**	634	4%	457	3%	397	4%
Appointments to see the dentist have to be made too long in advance	**	**	**	**	1,917	12%	1,679	13%	1,569	14%
2 weeks	**	**	**	**	**	**	**	**	178	2%
3 weeks	**	**	**	**	**	**	**	**	223	2%
4 or more weeks	**	**	**	**	**	**	**	**	1,168	10%
Not being able to see a dentist when the need is urgent	**	**	**	**	1324	8%	973	7%	780	7%
Not satisfied with the hours or days a primary care dentist's office is open	**	**	**	**	587	4%	512	4%	466	4%
Problem getting help or advise during regular office hours	**	**	**	**	478	3%	477	4%	417	4%
I need an interpreter but dentist's office does not have one	**	**	**	**	343	2%	268	2%	217	2%
Dentist's office is too far away	**	**	**	**	1,408	9%	1,106	8%	912	8%
1 to 5 miles	**	**	**	**	121	1%	103	1%	125	1%
6 to 10 miles	**	**	**	**	385	2%	281	2%	224	2%
10 miles or more	**	**	**	**	886	6%	684	5%	563	5%
Children are discriminated against because they are enrolled in Healthy Families.	**	**	**	**	342	2%	373	3%	317	3%
Other:	**	**	**	**	1,841	12%	1,352	10%	1,270	11%
Total	473	100%	1,737	100%	15,985	100%	13,338	100%	11,152	100%

Legend
* The wording of the question has changed. The meaning is generally the same.
** The question was not included in that year's survey.